Evaluation of the UNICEF Social Cash Transfer Pilot Programme in SNNPR, Ethiopia

MIDLINE REPORT
- FINAL -

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Executive Summary

This report presents midline findings for the Integrated Nutrition Social Cash Transfer (IN-SCT) pilot project in SNNPR in Ethiopia. The project falls under the umbrella of Ethiopia's Productive Safety Net Programme, phase 4 (PSNP4) that was launched in 2015 and aims to test an integrated package of linkages to services and multisectoral nutrition services in a bid to improve nutritional and other outcomes. This qualitative study is part of the project's mixed methods impact evaluation, presenting a process-oriented investigation and focusing on issues of efficiency, effectiveness and sustainability mid-way through project implementation. The study was undertaken in Girme kebele in Halaba Special woreda and included interviews with programme staff, group discussions and case studies with PSNP clients and non-clients.

Findings indicate that generally the pilot project is implemented well. Monitoring and follow-up of co-responsibilities and supporting smooth transitions of pregnant and lactating women (PLW) from Public Works (PW) into Temporary Direct Support (TDS) – key components of the pilot – were functioning well with both service providers and clients having strong awareness of procedures and mostly positive experiences with implementation. Case management of child protection cases was found to be limited but positive in cases where it did happen, and the project is able to link into the well-established PSNP grievance mechanism. Increased collaboration between programme stakeholders – from national level down to kebele and community level – was considered a crucial element for success of those and other components, with many service providers indicating that the pilot had contributed to improved collaboration. Clients greatly appreciated the support provided by social workers (SWs), development agents (DAs) and health extension workers (HEWs) respectively, all serving to improve knowledge and awareness regarding feeding, health and sanitation practices and agriculture respectively.

Findings also point towards a number of challenges, primarily referring to issues that compromise the performance of service providers' roles in the IN-SCT. Staffing challenges include high attrition and staff turnover, recruitment delays, work overload and language barriers. These factors undermine service providers' capacity to perform their roles in a timely and adequate manner, leading to frustration on behalf of both staff and clients. These challenges are compounded by technical problems such as delayed MIS software development and late payment of PSNP clients and logistical constraints pertaining to lack of adequate transport and remote communities, further straining service delivery. Finally, the pilot has suffered from structural and practical issues that affected clients' participation. Drought and water shortage, many other pressures and infirmity has limited clients' responsiveness and attendance at meetings.

Key recommendations refer to further strengthening coordination of all service providers, both at higher levels and within communities – such as having a clear protocol for the woreda-level steering committee and regular cross-sectoral meetings at the community level – improvements to staff's capacity to implement all components of the project – such as ongoing training on the pilot (in light of staff turnover) and more appropriate modes of transportation – and changes to implementation procedures and tools to further improve awareness of clients – such as visual forms of information provision regarding co-responsibilities and clarifying the role of HEWs in provision of primary care.

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Acknowledgements

List of Acronyms

BCC   Behaviour change communication

CCC   Community Care Coalition

CFSTF   Community Food Security Task Force

CSP   Centre for Social Protection

DA   Development Agent

DS   Direct Support

FGD   Focus group discussion

FTC   Farming Training Centre

HEW   Health Extension Worker

IDS   Institute of Development Studies

IFPRI   International Food Policy Research Institute

IN-SC   Integrated Nutrition and Social Cash Transfer

KFSTF   Kebele Food Security Task Force

KAP   Knowledge, Attitude and Practices

KII   Key informant interview

MoARD   Ministry of Agriculture and Natural Resources

MoE   Ministry of Education

MoH   Ministry of Health

MoLSA   Ministry of Labour and Social Affairs

NGO   Non-governmental organisation

NNP   National Nutrition Programme

PDS   Permanent Direct Support

PLW   Pregnant and lactating women

PO   Participant observation

PSNP   Productive Safety Net Programme

PW   Public works

RFP   Request for Proposals

SW   Social Worker

TDS   Temporary Direct Support

UNICEF   United Nations Children's Fund

List of codes used in presentation of data

<u>Region</u>

SN   SNNPR

<u>Woreda</u>

H   Halaba

<u>Kebele</u>

G   Girme

<u>Interview type</u>

KII   Key informant interview
FGD   Focus group discussion
CS   Case study

<u>Respondent category</u>

RSCT   Regional SCT coordinator
SCT   Woreda SCT coordinator
WoLSA   WoLSA SP core process owner
PSNP   PSNP coordinator
SW   Social Worker
MIS   IN-SCT MIS focal person
SCT   SCT Steering Committee
DA   Development Agent
HEW   Health Extension Worker
CCC   Community Care Coalition
PDS-M   PDS client male
TDS-F   TDS client female
PW-F   PSNP PW client female
PW-M   PSNP PW client male
NonC-F   Non-client female
NonC-M   Non-client male

1. Introduction

The Integrated Nutrition and Social Cash Transfer (IN-SCT) pilot project falls under the umbrella of Ethiopia's Productive Safety Net Programme, phase 4 (PSNP4), which was launched in 2015 and includes several innovations designed to strengthen the programme and improve its outcomes (MoARD, 2016). Changes include increases in the quantity and duration of transfers and greater integration with delivery of social services such as health and nutrition. The IN-SCT pilot aims to test an integrated package of multisectoral nutrition services in Halaba Special Woreda and Shashago woredas in SNNPR, supporting several nutrition-sensitive interventions under PSNP4 and also engaging in activities to strengthen the quality of social and health services offered. In Oromia, a less intensive version of the pilot programme is being implemented in Dodota and Adami Tulu woredas. Most notably it does not include nutrition-sensitive components such as cooking demonstrations, nutrition clubs and nutrition-sensitive public works.

The International Food Policy Research Institute (IFPRI), the Centre for Social Protection (CSP) at the Institute of Development Studies (IDS), University of Sussex and Cornell University are conducting an evaluation of the IN-SCT pilot programme from early 2016 to mid-2018. A quantitative and qualitative baseline survey was conducted from April to May 2016 in SNNP and Oromia regions (Gilligan et al. 2016). This midline report presents findings from a qualitative follow-up midline survey in SNNPR in April-May 2017. It particularly aims to understand effectiveness of the IN-SCT pilot and its components and to illuminate bottlenecks and implementation challenges that can be addressed in the second phase of pilot implementation.

1.1. Background

The IN-SCT pilot is embedded within the PSNP4 structure and is implemented in two PSNP woredas (Adami Tulu and Dodota) in Oromia region and two PSNP woredas of SNNPR (Halaba and Shashego). PSNP4 introduced a number of innovations in a bid to improve impacts: Permanent Direct Support (PDS) clients – clients who experience no temporary changes in their labour constrained capacity – will now receive payments for 12 months as opposed to just 6 months per year while pregnant and lactating women (PLW) and caregivers of malnourished children will move from Public Works (PW) to Temporary Direct Support (TDS). Co-responsibilities have been introduced for TDS and PDS clients[1].

The IN-SCT pilot aims to reinforce these innovations and achieve increased uptake of social services by PDS and TDS households as well as improved knowledge, attitudes and practices of PDS and TDS households as well as Public Works households regarding nutritional, sanitary, health, child protection and educational behaviour. The pilot also seeks to create a better understanding of the agreed roles and responsibilities of community-based actors such as social workers and community-based committees in achieving improved outcomes (Schubert, 2015).

In SNNPR, the pilot supports implementation of the nutrition-sensitive interventions of PSNP4, such as behaviour change communication (BCC) for PW clients and linking DS clients to health and other social services (MoARD, 2016). Capacity building and related asset support to nutrition-sensitive

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[1] Co-responsibilities include: attend 4 antenatal care visits; obtain postnatal care; obtain vaccination of children; attend monthly growth monitoring for children; attend BCC sessions; complete birth registration; and for children aged 6-18 to go to school (for PDS clients only).

agriculture activities – including the establishment of the farming training centres, promotion of school gardens, establishment of nutrition clubs at schools as well as the general promotion of nutrition-sensitive social protection and implementation of comprehensive training curriculum – will be provided by Concern Worldwide[2]. This is in line with UNICEF's wider systematic approach to improving nutrition outcomes, acknowledging that improved nutrition requires availability of food, knowledge about feeding practices and appropriate hygienic and care practices.

The Ministry of Labour and Social Affairs (MoLSA), with support from UNICEF and Irish Aid, implements the pilot in collaboration with the regional and woreda level representatives of the Ministry of Agriculture and Natural Resources (MoARD), Ministry of Education (MoE), and Ministry of Health (MoH). The pilot promotes linkages and tests tools in terms of information sharing, case management and capacity building that can potentially be scaled up to other PSNP woredas. This includes the roles for social workers and Community Care Coalitions (CCCs) in providing case management and setting up linkages between services for PDS and TDS clients, and the process of shifting responsibility for PDS clients from MoARD to MoLSA. While MoARD has so far been responsible for implementation and administration of both Public Works and Direct Support components within the PSNP, in the long term responsibility for implementation of Direct Support will move from MoARD to MoLSA. The lessons drawn from this pilot will inform future design and implementation of the NNP and PSNP (UNICEF, 2014).

1.2. Objectives of study

This midline study provides follow-up analysis based on the baseline study, particularly aiming to gain further insight into bottlenecks in achieving improved nutrition and challenges with programme implementation as identified at baseline. The main issues that were identified as obstructing improved nutritional outcomes include:

- Low intake of nutritious foods (i.e. only small proportions of children consumed milk, eggs or green leafy vegetables),
- Lack of access to quality water (primarily due to drought),
- Poor hygiene and sanitation practices (i.e. unclean living conditions with animal fecal matter and garbage present and limited use of soap when washing hands),
- Lack of access to services and low utilisation of services.

Main findings with respect to programme implementation included:

- Clients were positive about the support that they received from SWs but only a minority of clients knew the SW in the area.
- Support from HEWs was widespread and longstanding and was considered to have contributed to the high baseline levels of knowledge of nutrition and health practice.
- Staff at woreda and kebele levels directly involved in implementation of the IN-SCT – SCT coordinators, SP process owners and SWs – were highly aware of management and administration processes.

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[2] Activities carried out by Concern Worldwide include training of model farmers, training of DAs on improved farming techniques and provision of cooking demonstrations.

- HEWs had modest to limited understanding of programme objectives and implementation modalities of IN-SCT and their role within the programme.

The midline study focuses specifically on three of five OECD-DAC Criteria for Evaluating Development Assistance (OECD 1991), namely efficiency, effectiveness and sustainability. With respect to **efficiency**, the research considers to what extent programme components are implemented according to programme guidelines, identifying implementation challenges and suggestions for improved implementation in the second year of programme implementation. It also considers questions of **effectiveness** and **sustainability** based on clients' and service providers' perceptions of programme components' general impact on programme outcomes and basic ideas regarding sustainability of such components in the long term. Programme outcomes under consideration include school enrolment and birth registration within the wider range of education, child protection, health, sanitation and nutrition outcomes. Questions of relevance – i.e. the extent to which the project meets its objectives – and impact – i.e. the extent to which the project results in change – were considered beyond the remit of this more practically and process-oriented midline survey and will be taken in consideration in the endline study.

The midline study assesses these issues of efficiency, effectiveness and sustainability by specifically considering the following programme components:

- *Programme management:* to understand managerial meetings, monitoring visits, and staff turnover.

- *Implementation of shift of PLW from PW to TDS*: to gain insight into the processes of identification of PLW, confirmation of pregnancy, and transition from PW to TDS.

- *Implementation of inclusion of caregivers of malnourished children into TDS*: to understand the processes of identification of malnutrition, transition from PW to TDS or from non-PSNP into TDS.

- *Implementation of co-responsibilities for DS clients:* to assess communication of co-responsibilities to DS clients, monitoring of compliance with co-responsibilities, and support and follow-up in case of non-compliance with co-responsibilities.

- *Case management*: to assess the extent to which the IN-SCT pilot supports identification of needs and response beyond [non-]compliance with co-responsibilities, the provision of support and follow-up and monitoring, and the capacity of social workforce for undertaking case management.

- *Grievance mechanisms*: to gain insight into clients' knowledge and use of such mechanisms and the extent of follow-up to grievances.

- *Collaboration between IN-SCT service providers*: to assess the collaboration between SWs, HEWs, DAs, CCCs and teachers/school directors and challenges towards effective service integration and provision.

- *CCC:* to assess their functioning and contribution to envisaged outcomes.

- *Management Information System (MIS)*: to assess its functionality and operation by SWs and dedicated staff at woreda level.

2. Methodology

The overall evaluation study is designed as a mixed methods evaluation, including both quantitative and qualitative evaluation components. The study includes two rounds of quantitative data collection. A baseline household survey was conducted from April to June 2016. An endline household survey is scheduled to be implemented two years later. The quantitative evaluation component focuses on estimating impacts that can be attributed to the IN-SCT pilot and PSNP4 respectively (Gilligan et al. 2016). The study includes three rounds of qualitative data collection based on series of semi-structured key informant interviews, focus group discussions, group exercises and household case studies. The qualitative component aims to add depth and allows for unpacking the observed impacts (or lack thereof) of the IN-SCT pilot. More detail about the design of the impact evaluation study can be found in the Inception Report (Devereux et al., 2016).The first round – the baseline survey – took place from March to April 2016. The final round – the endline survey – is scheduled for March to April 2018. The midline survey – the focus of this report – took place from March to April 2017.

The midline qualitative research aims to assess the performance of programme components at a time that allows for mid-course corrections or improvements to implementation, as needed. As such it presents a form of 'action research' by reporting the perceptions and experiences of clients and service providers so far and providing information for programme improvements on that basis. The qualitative baseline research addressed two sets of issues, essentially representing two sub-studies. Firstly a '<u>process evaluation</u>' focused on how efficiently and effectively the programme and its components were being implemented. Secondly, an '<u>impact evaluation</u>' assessed what difference the programme is making to people's lives, in terms of the key indicators of interest including exclusive breastfeeding, handwashing practices and child marriage. In reference to the structure of the baseline research, the midline survey is primarily focused on 'process evaluation' with some additional questions referring to impact and sustainability. In terms of the DAC criteria, this covers efficiency, effectiveness and sustainability.

2.1. Methods

The methods used for midline data collection are (1) key-informant interviews (KIIs), (2) focus group discussions (FGDs), and (3) case studies (CSs)[3].

KIIs were primarily used to gain insights from programme staff at regional, woreda and kebele level, allowing for structured discussions to explore perceptions of and experiences with the implementation of the IN-SCT. Interviewees were also asked to reflect on their perception of the impact and sustainability of the pilot. FGDs were used to explore perceptions and experiences of clients with respect to process and impact using semi-structured interview techniques. Sets of questions were framed around main programme components, including transition into TDS, co-responsibilities, grievance mechanisms and access to services. Finally, CSs were used to gain in-depth insight into households' past and present living conditions and into their experiences regarding participation in the IN-SCT. All CS respondents were also included in the first round of data collection, providing us with longer term perspectives for these selected households.

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[3] The fieldwork guide can be made available upon request.

Questions[4] regarding **efficiency** include: *"What are some of the challenges that you encounter with respect to [IN-SCT component]?"*, *"What do you think works well in implementation with respect to [IN-SCT component]?"*, and *"What changes can you recommend to improve [IN-SCT component]?"* This set of questions represents the majority of qualitative data collection efforts and can be considered part of the 'process evaluation' as mentioned above.

The main questions regarding **effectiveness** are: *"How well does [IN-SCT component] contribute to improving outcomes for children?"*, and *"How much impact has the IN-SCT on the various outcome areas for children?"* probing for differential contributions to school enrolment and birth registration, and wider contributions to nutrition, health, education and child protection outcomes[5]. These questions would be part of the 'impact evaluation' component as mentioned above.

The main questions regarding **sustainability** for woreda-level KIIs were: *"How do you see the long-term future of the systems (including case management) being built through IN-SCT?"* and for kebele-level FGDs: *"Do you think that you will continue to receive support through PSNP in the future? Why?"* and *"What will be the long-term impact of the PSNP and IN-SCT on you, your family and the community?"* This is a new set of questions that considers the long-term feasibility of programme implementation.

2.2. Sampling

Fieldwork was undertaken in one kebele within one woreda, namely Girme kebele in Halaba woreda. This kebele was purposively selected for consistency purposes; this kebele was also included in the baseline survey. The sampling frame was also kept consistent with the baseline survey, including the same types of activities and stratification of those activities in line with baseline data collection.

The sampling frame is presented in Table 1.

Quotes in the text are followed by an identifier code that reflects the location and respondent type. SN and G reflect the region (SNNPR) and kebele (Girme) respectively, while the remainder of the code identifies the fieldwork activity (KII, FGD, CS), respondent group (see acronyms used in the List of Acronyms and in the table below) and gender (F=female, M=male).

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[4] Questions have been rephrased to fit the respective programme component and respondent category.
[5] Note that the limited remit of the midline survey and its focus on 'process evaluation' does not allow for assessments of the contribution of individual programme components to the individual outcome areas.

Table 1. Sampling framework

Location	Key Informant Interviews (KIIs)	Focus Group Discussions (FGDs)					Case Studies (CSs)		
		Committees	Non-clients [NC]	Permanent Direct Support [PDS]	Temporary Direct Support [TDS]	Public Works [PW]	Permanent Direct Support [PDS]	Temporary Direct Support [TDS]	Public Works [PW]
National	- Concern national coordinator [Concern]								
Region (SNNP)	- Regional SCT coordinator [RSCT]								
Woreda (Halaba)	- SCT coordinator [SCT] - WoLSA SP core process owner [WoLSA] - PSNP coordinator [PSNP] - Social Worker [SW] - MIS focal person [MIS] - Concern coordinator [Concern]	- SCT steering committee [SCT]							
Kebele #1 (Girme kebele)	- Health Extension Worker [HEW] - Development Agent [DA]	- CCC	- 1 male group - 1 female group	- 1 female group - 1 female group	- 1 female group (PLW) - 1 female group (caregivers of malnourished child)	- 1 male group - 1 female group	- 1 male PDS client with at least one child <18 - 1 female PDS client with at least one child <18	- 1 female TDS client (PLW) - 1 female TDS client (caregiver of malnourished child)	- 1 male PW client with at least one child <18 - 1 female PW client with at least one child <18
Total	**10**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**

2.3. Fieldwork challenges

Various challenges were encountered during the fieldwork. In the following, we discuss these challenges and how they were addressed.

A first challenge pertained to difficulties finding male PDS clients to participate in the focus group discussion (FGD). This is due to the reduction of the PDS quota by the regional government, notably from 20% during PSNP3 to 10% during PSNP4[6] as well as due to the difficulty of finding PDS clients in their homes at the time of fielwork. In order to mitigate impact of a low number of male research participants on quality of data, fieldworkers worked to capture as much information as possible from the male PDS case study and by probing female PDS clients regarding gender issues.

A second challenge pertained to tracking case study respondents who were also included in the baseline survey. One client who was interviewed during the baseline was not in the village during this midline survey. She was out of the kebele for some weeks due to family reasons. To address this, the field researchers worked closely with the social worker and kebele administrator in order to access the case study respondent. Finally, she came back to the kebele and managed to attend the interview.

Thirdly, drought or delayed rainfall also impacted data collection and content of discussions. Respondents – particularly PDS clients and PLW – repeatedly mentioned drought and late onset of the rains as a burning issue affecting them. There was a tendency to focus on these urgent issues rather than respond to survey questions. In order to minimise the impact of this on the quality of data collection, the field researchers listened to their views, appreciated the problems, and then systematically drew their attention back to the questions at hand by explaining the purpose of the assignment.

Finally, the delay of PSNP transfer payments also challenged the process of data collection. Many of the respondents frequently indicated these delayed PSNP transfers as another key challenge impacting on their families.

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[6] This process was described to the fieldworkers by service providers including the SW and DA.

3. Project management

This section discusses the roles and responsibilities of the main project staff and committees involved in delivering the IN-SCT, how the project interacts with the PSNP4, project meetings and field visits, and operational challenges faced such as personnel issues.

3.1. Roles and responsibilities

Different actors have clearly defined roles and responsibilities in the IN-SCT project. The fieldwork tested the understanding of this, by asking different actors to describe their roles and responsibilities. The discussion below reflects service providers' own understandings of their roles and responsibilities.

The three key officials who interact directly with programme participants on a daily basis are the Social Worker (SW), Development Agent (DA) and Health Extension Worker (HEW).

A **Social Worker** described how she works in coordination with other sectors and committees to deliver the PSNP and the IN-SCT.

> *"I am responsible for the six kebeles and I work together with the other service providers on PDS and TDS. I am mainly working with the DAs and the HEWs. I travel to communities with them together. I also do house-to-house visits. I also have monthly meetings with community committees. This includes the KFSTF and the CCC."* [SN-G-KII-SW]

The SW also indicated to be part of the process of retargeting of PSNP, informing clients of co-responsibilities and following up on those co-responsibilities in collaboration with HEWs, DAs, CCCs and the school director:

> *"One of the tasks at kebele level is that we receive lists of PSNP participants from woreda FSTF office officials and then we go to the kebeles to update. We are still in the process of re-targeting. We also distribute the co-responsibilities using the forms 3a, 3b and 3c at household level. It is distributed in different ways. If it is possible to bring people together in the community, we do it there and otherwise we do it at the house. These co-responsibilities are also distributed to the HEWs (these list of beneficiaries are also given to the HEW to do follow up with form 4A, 4B and 4C). I also do case management using form 5 by collaborating with other service providers such as the school director, DA, HEW and CCC. Once the co-responsibilities are given to the household and also the service providers, then there is follow-up about those co-responsibilities."* [SN-G-KII-SW]

Responses by clients also indicate that the SW plays an important role in creating awareness about the move into TDS for either PLW or caregivers of malnourished children. They may also offer more direct referral to the HEW for a pregnancy test in case they learn of a PSNP client being pregnant.

One **Development Agent** explained that his involvement started before the project was launched, with assessing household wealth status for PSNP beneficiary selection. He is currently engaged in organising and monitoring PW activities, including keeping daily attendance records that he submits to the woreda Agriculture Office for payment. He also arranges for the transfer of PLW and caregivers of malnourished children from PW to TDS, based on the information from the HEWs. He delivers BCC sessions, offers technical advice to farmers through home and farm visits, and works closely with the local HEWs and SW. He is an active member of the woreda CCC.

The BCC sessions provided by DAs was linked to the PW activities and focused on agriculture: *"BoA is involved in […] implementing PW activities, moving PLW and mother with malnourished child to TDS, facilitating cash transfer and handling BCC sessions related to agriculture"* [SN-G-KII-PSNP]. This was corroborated by male PW clients: *"The DAs gives us extension service through field (home) visit, demonstration at FTC (Farmers Training Centre), and BCC sessions at PW site. The extension and education service we get from DAs are on agronomic practice like repeated ploughing, proper weeding, row planting, crop-rotation, fencing farmlands adjoining pathways (road), proper fertilizer dose and type"* [SN-G-FGD-PW-M].

A **Health Extension Worker** revealed that she has a number of specific responsibilities in supporting the IN-SCT. These include:

- informing the DA about pregnant women and caretakers of malnourished children on PW, so that s/he can transfer them from PW to TDS;

- providing ante-natal and post-natal care and check-up services for pregnant and lactating women (PLW), including vaccinating infants and referring cases to the kebele health centre if needed;

- identifying malnourished children during home visits, giving treatment and supplementary food such as plumpy-nut, then conducting follow-up and supervision until the child recovers;

- raising awareness about family planning, birth registration, hygiene and sanitation, latrine construction and utilisation in BCC sessions;

- mobilising community members or PW participants to construct latrines and clean the homes and compounds of elderly and disabled PDS beneficiaries;

- visiting non-compliant clients together with the social worker, development agent and kebele chairman, to identify reasons for non-compliance with co-responsibilities (e.g. sending children to school) and finding solutions together.

There appeared to be confusion as to what constitutes birth registration. Both the HEW and the SCT coordinator indicated that birth registration has increased because almost all births now happen in the health centre and are therefore registered in family folders. Indeed, other service providers also indicated that births at health centres have greatly increased due to advice and awareness raising as well as the instalment of a 1,000 Birr fine in case women deliver at home: *"Many kebeles announced a penalty of up to 1000 birr if any women give birth at home. […] currently every pregnant women is giving birth at health centres and getting birth registration"* [SN-G-KII-SCT-M] and *"Birth registration is one of health service given priority by HEW. […] All HH have family folder and all important data are recorded starting from pregnancy, 4th month, birth, vaccination etc., and the program is supporting this by providing training, social worker follow up. This definitely improved birth registration"* [SN-G-FGD-SCT]. Yet fieldworkers observed that formal birth registration had not yet been fully rolled out in Girme kebele and that the process of registration at the health centre does not constitute formal birth registration. This is corroborated by the response by the SW: *"the office is established at woreda level and they have the information since July 2016, but no-one comes here to collect that information, maybe they do not have staff to do this. If a pregnant woman delivers, we use information from the HEW not from the birth registration office – maybe the HEW sends this information to the woreda office. Birth registration is a co-responsibility in form A2, but the follow-up so far is weak"* [SN-G-KII-SW]

The woreda-level **SCT coordinator** provided the longest list of responsibilities of anyone interviewed:

- prepare detailed activity plans – yearly, quarterly and monthly – and share to all concerned offices and individuals;
- provide technical assistance to WoLSA staff;
- provide capacity building to social workers and kebele-level service providers – DAs, HEWs, CCC committee members, and appeal committees;
- oversee the day-to-day IN-SCT project implementation;
- managing the resources allocated for the project;
- organise and facilitate project events such as review meetings, experience sharing events, field visits, and evaluations (baseline and mid-line);
- contribute to the preparation of standard operational procedures (SOPs) for multi-stakeholders to work together in an integrated manner;
- communicate with all concerned offices and individuals to create smooth relationships and to facilitate the project implementations;
- compile the project related data and submit timely reports to all concerned offices;
- attend management meetings and present progress reports to the woreda steering committee.

The **PSNP coordinator** in Halaba explained that he was involved in beneficiary targeting and re-targeting (mainly moving clients who were wrongly placed from PW to PDS), following up on cash transfers for PDS clients, following up the movement of PLW and caregivers of malnourished children to TDS, and monitoring linkages of PDS and TDS clients with service providers (schools, HEWs and DAs) [SN-G-KII-PSNP].

The **SCT Steering Committee** was also asked in a focus group discussion about their activities and responsibilities at *woreda* level. Members of this Steering Committee include *"Education, Women Affairs, Health, Justice and Administration offices"* [SN-G-FGD-SCT]. They also include the WoLSA unit coordinator and the Food Security (FS) and Disaster Risk Reduction (DRR) department heads: *"I also attended on steering committee meeting in this month"* [SN-G-KII-WoLSA] and *"I am not member of the IN-SCT committee rather my immediate supervisor (FS and DRR department head) are members"* [SN-G-KII-DA. The Steering Committee has a meeting each month with project staff, notably the SCT Coordinator, and also Concern, to discuss and review progress against project plans.

One respondent explained that committee members work in their independent roles – rather than collectively – to monitor the IN-SCT project. *"All relevant offices are members and though not as a team, respective members take assignments and do field supervision in relation to health, education, agriculture, etc. All bring their respective reports and discuss at the Steering Committee meeting, where Administration chairs"* [SN-G-FGD-SCT].

3.2. Project meetings

All SCT Steering Committee members agreed that they have one regular IN-SCT management meeting at woreda level every month. *"We meet every month and have minutes. All sectors present their report and we agree on next directions"* [SN-G-FGD-SCT]. *"Even if there are overlaps of duties we do not miss monthly meetings. Some of the members may be on mission and in most cases there are absent members while the majority attends"* [SN-G-FGD-SCT]. At the kebele level meetings are held every week, usually on a Monday morning, to plan work activities for the week ahead.

During times of intense project-related activities additional meetings might be scheduled. *"We have meetings once in a month, but the frequency increases during beneficiary selection and re-targeting, and when hot issues arise"* [SN-G-KII-RSCT]. An example of a 'hot issue' was provided by a PSNP

worker: *"The first two meetings conducted after my assignment to my new position was about re-targeting. There were targeting problem in the first round and in these meetings direction was given about how to perform fair re-targeting by avoiding bias and leakage"* [SN-G-KII-PSNP].

In Halaba woreda, SCT steering committee meetings are usually attended by the SCT coordinator who chairs the meeting, the PSNP unit coordinator, WoLSA unit coordinator, and four office heads – the Woreda Administrator and Health, Agriculture and Education offices. WoLSA office-level management meetings are led by the WoLSA unit coordinator or SP core process owner, and are attended by all social workers, the MIS officer, WoLSA officers and the SCT project coordinator.

In these meetings, all sectors and service providers – including each social worker in the woreda-level meetings – present a progress report on their routine project activities, and challenges faced during implementation. Among the issues arising that are discussed, the following recur repeatedly:

- work overload of the social workers*: "there are some challenges such as the SWs are tight with work overload"* [SN-G-KII-WoLSA]. Social workers indicated to cover roughly 15 to 22 PDS client households per kebele and to reach out to 5 to 6 kebeles on average. This does not include TDS client households or any other households for case management.;
- inadequate support from other SCT actors involved *("most of the service providers (HEWs, DAs, school directors, kebele managers and kebele chairmen) are busy with their routine activities and give less time for the social worker to discuss issues, to provide timely follow-up reports, to conduct CCC meetings, and to go with the social workers for case management"* [SN-G-KII-SCT);
- delays in disbursement of monthly cash transfer payments from region to woreda level: *"The main challenge is delay of transfer due to fund transfer delay from the region"* [SN-G-KII-PSNP];
- re-targeting *("how to take corrective action, by replacing mis-targeted clients with eligible ones who were not targeted during the first targeting"* [SN-G-KII-PSNP-M];
- how to strengthen linkages of PSNP families with service providers;
- how to monitor the co-responsibilities of each PSNP client category.

3.3. Field visits

Field visits to project sites by programme staff are conducted either at regular intervals, such as weekly or every second week, or on an *ad hoc* basis. *"There is a weekly planning meeting every Monday for Tuesday to Friday. On Tuesday they go to the project sites"* [SN-G-KII-SW]. *"Every other week, 3 to 5 days in 15 days are allocated for field visits"* [SN-G-KII-SCT-M]. *"We don't have a regular programme to conduct visits. We conduct kebele-level monitoring as cases are reported"* [SN-G-KII-PSNP].

Another important 'process' function of these field visits is for *"creating a good working environment and integration"* [SN-G-KII-SCT-M]. Cross-sectoral teams are created for these field visits. *"In these monitoring tasks staff from SCT, FS and DRR units form a team by pulling one expert from each unit, each team shares the 48 PSNP4 kebeles, where one team handles 6-10 Kebeles"* [SN-G-KII-PSNP].

Field visits are undertaken to monitor project activities and to engage with service providers at kebele level, following up on challenges identified in progress reports, visiting clients' houses to discuss issues such as non-compliance with co-responsibilities, and doing random checks such as visiting PW sites to discover if any pregnant women are working who should have been moved to TDS. *"Through such visits, we found pregnant women working on Public Works. In such cases we discuss with the woman whether she knows her entitlement for leave and question DAs why the leave was not implemented"* [SN-G-KII-PSNP].

4. Temporary Direct Support (TDS)

Temporary Direct Support (TDS) reflects the PSNP's gender-sensitive intentions as well as an effort to achieve better impacts for children and women in client households. This section reviews the understanding and implementation of TDS eligibility criteria and transition procedures, as well as implementation challenges, from the service provider as well as the clients' perspective.

4.1. Eligibility criteria and transition procedures

Service providers all demonstrated good awareness of the criteria and procedures for women to move from PW to TDS, and for caregivers of malnourished children to be registered on TDS. Social workers, DAs and HEWs agreed that: *"Once the mother is confirmed as pregnant by the HEW after 4 months she shall be removed from PW and receive DS until the child is one year old"* [SN-G-KII-SW]. In other words: *"All women in the PSNP Public Works, starting from the fourth month of pregnancy, will be transferred to TDS for 17 months"* [SN-KII-HEW].

However, the woreda SCT coordinator and the PSNP core process owner had a slightly different interpretation: *"We identified through monitoring that most of the service providers, especially HEWs, were informed that the starting time is at 4 months of pregnancy, which is wrong. It should be at any time when her pregnancy is known by urine test – it may be 1, 2, 3 months or beyond"* [SN-G-KII-WSCT]. *"According to the revised guideline, women are eligible to be moved to TDS from any time pregnancy is confirmed – it can be less than 4 months"* [SN-G-KII-PSNP].

There was consensus on the rule concerning caregivers of malnourished children: *"Everyone, man or women, who is a caretaker of a malnourished child, will be transferred to TDS until the child recovers"* [SN-G-KII-HEW-F]. A social worker explained the procedure as follows: *"The DA and SW refers any family with a malnourished child to a health post for consultation with the HEW. When confirmed, that information is returned to the DA and the caregiver is eligible for inclusion into DS"* [SN-G-KII-SW]. Unlike the 17-month inclusion period on TDS for pregnant women, the period of inclusion on TDS for caregivers is open-ended: *"The starting time is immediately the child is identified, but the time of return will be decided by the HEW based on the child's condition"* [SN-G-KII-WSCT].

The process of transferring pregnant women from PW to TDS is reportedly working well. The first step is awareness raising. *"At the Public Works site the DA simply makes people aware that they should visit HEWs if they feel they are pregnant"* [SN-G-KII-SW] or more direct referral by the DA or SW: "the DAs and SW refers any family with a malnourished child to a health post for consultation with the HEW" [SN-G-KII-SW]. Second, the woman visits a HEW to verify her pregnancy. *"The HEW diagnoses the woman and if she feels the woman needs a pregnancy test she refers her to a health centre, because tests are not available at health post level where HEWs work"* [SN-G-KII-SW]. Next, if the pregnancy test is positive, the HEW sends a confirmation to the relevant DA as well as SW and updates the family folder. *"Then I inform the DA to transfer her to TDS, because he is responsible to implement this"* [SN-G-KII-HEW]. *"Mothers are transferred to TDS and her family folder is updated"* [SN-G-FGD-SCT].The DA then removes the pregnant woman from PW and registers her for TDS, and explains which co-responsibilities will apply to her while on TDS: *"During her transfer both the HEW and the DA inform them about their co-responsibilities"* [SN-G-KII-DA].] Finally, the DA informs the SW, who will monitor co-responsibilities: "*We fill the detailed profiles of those PLWs and caregivers who transferred from PW to TDS by using the format we received from the SW and timely submitted to the SW"* [SN-G-KII-DA]

The process of registering caregivers of malnourished children for TDS is simpler, and also works well in practice, according to those responsible for its implementation. The first step is for a malnourished

child to be identified, either at the health post or during home visits by a HEW or SW. *"The child is identified at the health post through the growth monitoring process"* [SN-G-KII-SCT]. *"During home to home visits or when mothers come with their sick child to the health post, I identify a malnourished child"* [SN-G-KII-HEW]. Next the HEW starts treating the child with supplementary food and informs the DA. *"The HEW starts the treatment of the child, informs the mother how to give proper care for the child, and sends the mothers with a letter to give the DA"* [SN-G-KII-SCT]. The DA is responsible for implementing the registration of the caregiver on TDS. Finally, the HEW continues treating the malnourished child and informs the DA when the child has fully recovered, when TDS benefits stop. *"I also monitor caregivers of malnourished child and, when the child is recovered, I inform the DA"* [SN-G-KII-HEW]. According to one DA: *"The social worker is also monitoring its implementation"* [SN-G-KII-DA].

Women who are on TDS confirmed that the eligibility criteria and implementation procedures were clearly explained, thanks to awareness raising by social workers and HEWs. *"There is strong follow-up and awareness creation efforts from the SW and HEW that helped us know the criteria to be TDS"* [SN-G-FGD-TDS]. *"All pregnant women are aware of the conditionality [transition to TDS] as their right"* [SN-G-FGD-TDS]. This led to all PLW and caregivers of malnourished children in Girme kebele being transferred to TDS, after a slow start. *"At the initial stage, all were not being transferred to TDS, but now after awareness those who are pregnant and lactating are getting rest"* [SN-G-CS-TDS-F].

One TDS beneficiary noted the importance of good coordination between key service providers to make the procedures work well in practice. *"There is very good coordination between social worker, health extension worker and DA, so we believe it is going well"* [SN-G-FGD-TDS-F]. Another PLW commended staff for how quickly her transition from PW to TDS was done, and commented that this innovation was an improvement on previous phases of the PSNP. *"The transition was very smooth, for example in my case everything happened in one day. I was a beneficiary of PSNP3 for one year, where such support [exemption from PW] was not there at all"* [SN-G-CS-TDS-PLW].

Several TDS women shared their experiences of why and how they were registered for TDS, including their co-responsibilities (see Box 1).

Box 1. Client experiences of the transition into TDS
"Before the health worker and social worker started teaching us about TDS, we were working on the Public Works activities. In this phase of PSNP, we got awareness and knowledge. First, the health worker identified a malnutrition problem among our children and she told the DA to give us a rest from the Public Works, and then he gave us rest to take care of our children." [SN-G-FGD-TDS-F]
"When we observed some symptoms of pregnancy, we went to the health worker and told a detailed history of what we observed. Then the health worker took the full history and sent us to the health centre with a referral paper to do the pregnancy test. After doing a urine test we returned back to the health worker with the test result given by the health centre that verified our pregnancy. *Then the health worker referred us to the DA with a filled form in order to transfer us to TDS. She also informed us about what we should comply with during our pregnancy period and after delivery up to one year – such as ANC follow-up, to deliver at the health centre, to take vaccinations for us and for the child, and to give breast-feeding only to the child up to 6 months.* *The DA received the form, documented it and transferred us to TDS, informed us when we should return to Public Works, and re-informed us about our co-responsibilities."* [SN-G-FGD-TDS-PLW]
"The health worker informed us that we should care for our own health and for the baby in the womb, eat nutritious foods, come to the health post four times for ANC follow-up, take immunisation, deliver at

> *the health centre, follow the PNC visits and bring our children for vaccination and growth monitoring as per the schedule given to each child, and use bed-nets for ourselves and our children.*
>
> *The DA also informed us of some of these co-responsibilities. The total period to stay on TDS will be 17 months – 5 months before delivery and 12 months after delivery – and he added that we must send our children to school. Students should not be absent from classes."* [SN-G-FGD-TDS-PLW]

4.2. *Implementation challenges*

Although the procedure of transitioning pregnant women to TDS is well understood and seems to be generally well implemented, the PSNP core process owner acknowledged that implementation has been variable, especially during the initial stages. *"The moving to TDS is going well although the implementation varies from kebele to kebele. But as the programme is new there are some implementation gaps. In the initial time, women were not reporting their pregnancy and stayed on Public Works while being pregnant. The gap is reducing through time, as clients become aware of their entitlement"* [SN-G-KII-PSNP]. A social worker identified challenges related to **travel distance** and **payment of pregnancy tests**: *"There is one health centre in the six kebeles in this woreda, so all women have to travel there and also have to pay for the pregnancy urine test"* [SN-G-KII-SW]. But this does not seem to be a major obstacle.

One DA reported **challenges getting PLW to comply with the transition procedure**. At first, women who did not know or did not trust the new procedures chose not to reveal that they were pregnant in time. *"In earlier times, some women came too late to disclose their pregnancy to benefit from the move to TDS"* [SN-G-KII-PSNP]. Some pregnant women refused to stop working on PW, fearing that they would not be paid otherwise. *"At the start of its implementation, some women were suspicious that if they missed work their cash would be deducted, so they continued coming to Public Works. But after a while they accepted the rule"* [SN-G-KII-DA].

Lactating mothers who returned to PW from TDS often brought their infants with them, which created challenges in terms of breast-feeding while working, and also exposed the infants to dust and dirt. *"After a year, when mothers returned back to Public Works, most of us usually come to the work area with our young child and face problems to do the work and give care to our child"* [SN-G-FGD-TDS-PLW]. *"When the DA advised the mother not to bring her child, she usually gave the responsibility of taking care of the child to her school-going children until the mother returned from Public Works. These conditions forced the children to miss classes, which adversely affected one of the project outcomes"* [SN-G-KII-WSCT].].

A few women refused to return to PW after TDS. *"Rarely, some PLW did not return to work after they completed their allowed 17 months on TDS. We don't have proper tools to follow them and return them to work on time"* [SN-G-KII-DA].

5. Co-responsibilities

5.1. Awareness

Awareness of the existence of co-responsibilities is high across the large majority of respondents, including clients and service providers.

All clients were able to list actions and activities in response to the question of whether they could list co-responsibilities. A male PDS client indicated: *"The social worker informed us about the co-responsibilities such as to have a latrine and to continuously use it and to send our children to school"* [SN-G-CS-PDS-M] and a female TDS client said: "*As I am a TDS client since my pregnancy until now, I was given different co-responsibilities. My co-responsibilities include attending ante- and post-natal care such as follow-up regular check-up during pregnancy, vaccination of my newly born child and sending children to school"* [SN-G-CS-TDS-F].

The listing of co-responsibilities also suggests that clients receive more general advice about spending of transfers and hygienic practices, which they do not distinguish from co-responsibilities. Female PDS clients listed: *"To send our children to school. To have latrine and to use it continuously. To feed properly by using the cash we received. To keep our cleanness and take care of our health. To save some amount of money from the cash we received from PSNP"* [SN-G-FGD-PDS-F]. A group of male PDS clients provided a similar list but at the same time indicated that they had not heard of co-responsibilities: *"There are no co-responsibilities that are expected from us. However* they [SW, HEW, DA] *told us to send our children to school and we are doing that"* [SN-G-FGD-PDS-M].

Lack of clarity about what constitutes a co-responsibility may in part be explained by the fact that information about co-responsibilities appears to have been provided orally. None of the clients reported having received a form listing their co-responsibilities: *"No, we didn't receive any form, they (the DA, HEW and SW) simply informed us orally"* [SN-G-FGD-TDS-F-PLW]. TDS clients referred to posters they received from HEWs with advice on feeding and hygienic practices: *"We did not see any form you are explaining to us. But the health extension gave us some paper to be posted on our wall with pictures that the HEW told us to refer to during handwashing, otherwise during cooking. It also shows the role of men and women in child care"* [SN-G-FGD-TDS-F].

The SW, HEW and SCT coordinator were all able to articulate the process of co-responsibilities and their role in implementing them. The HEW said:

> *"I give awareness to pregnant clients regarding their co-responsibility. I advise them to follow ante-natal care starting from fourth months of pregnancy up to birth, to bring their children for vaccination 45 days after birth and to follow BCC sessions. I also advise caregivers of malnourished children to follow BCC sessions. In addition to giving advice and awareness about co-responsibilities, I also give all services like vaccination, BCC sessions two times per month to PLW and PDS clients. I also give special care to PDS (cleaning their home and environment, wash their cloth and construct latrine) by mobilising voluntary people with the DA"* [SN-G-HEW].

The WoLSA SP core process owner indicated to be less familiar with the co-responsibilities and their process of implementation, as she had only taken up office two months earlier. This is an example of the problems created by high staff turnover, as discussed in section 3.5.1 above.

In contrast to what was reported by the clients, the SW indicated that all PDS clients in the woreda had received their forms: *"All PDS (about 156 in 6 kebeles, 51 are female) have been given their co-responsibilities. They have all received their forms"* [SN-G-KII-SW].

5.2. Adherence to co-responsibilities

Responses with respect to the ability to adhere to the co-responsibilities are mixed. Some PDS and TDS clients indicate that there are no problems at all, others point towards challenges.

One issue pertains to the delay in payments, causing children to miss school as they had to go out in search of work: *"[…] since our payment is usually delayed, our children missed their classes or totally stopped and search jobs to fill the food gaps of the family"* [SN-G-FGD-PDS-F].

A second issue relates to the size of the transfer, which some indicated to be insufficient to cover food expenses and expenses related to schooling: *"[…] the cost related to education is not affordable for the PSNP-clients like me since the amount of money is very small and couldn't be excess from food"* [SN-G-CS-PDS-M].

A third issue concerns children's roles in income generation and how the co-responsibility of school attendance restricts children's roles, particularly for families with limited labour capacity. This includes households headed by elderly PDS clients as well as pregnant and lactating women. For women, this appears to increase their work burden considerably. One lactating women said: *"Yes, there are some challenges. Previously my daughter was helping me at home (cooking, fetching water and fuel wood collection) and my son was serving as a herder during the day. But after their school enrolment, I have to engage in all work alone until they back from school, this added a lot of work burden to me"* [SN-G-CS-TDS-PLW].

Responses by service providers echo these issues raised by clients. The HEW said: *"Some families have shortage of cash to implement the co responsibilities like sending children to school, buying soap for sanitation. […] Some PDS have challenge in latrine construction because they are unable to do"* [SN-G-KII-HEW] and also indicated that supplementary food for malnourished children is shared amongst all children. The SCT coordinator described how the delay in payments causes challenges for clients: *"Delay of cash transfers to the clients hindered them to comply with their co-responsibilities and hinder our intervention outcomes"* [SN-G-KII-SCT].

Service providers also referred to other challenges, which include lack of awareness about the importance of education and issues related to hygiene and health and water scarcity. CCCCCC members also indicated: *"[Challenges with respect to implementation of co-responsibilities include] inadequate level of awareness and knowledge among rural women (clients) on nutrition, healthy feeding, and other improved practices",* and *"aspects like water scarcity are affecting hygiene and sanitation"* [SN-G-FGD-CCC].

CCC member also highlighted positive trends and positive changes over the course of programme implementation, with adherence to co-responsibilities having improved over time and clients understanding the benefits of education and hygienic practice: *"The clients are obeying co-responsibility. There are very limited cases of refusing co-responsibility, it was happening at beginning of the programme. Co-responsibilities like antenatal and postnatal care, child immunisation, personal and environmental hygiene and sanitation and use of toilet are well taken"* [SN-G-FGD-CCC].

5.3. Monitoring and follow-up

Both PDS and TDS clients indicate that there is strong regular monitoring by the SW and HEW with interactions generally ranging between once per week to once per month. All respondents indicate receiving frequent home visits, particularly by the SW but also in collaboration with the HEW and DA. Home visits can be prompted by failure to comply with co-responsibilities (such as children not going to school) or can be part of regular monitoring. A male PDS client indicated: *"The social worker visited*

us and asked how we are doing, whether we received the cash or not, how much we received, how we are using the cash transferred, do the children attend school, do we use the latrine properly. The health extension worker also sometimes visited us and asked similar questions" [SN-G-CS-PDS-M]. Female TDS clients referred to the specific role of school teachers in monitoring school attendance: *"The school teachers also strictly following the students' attendance from the PSNP families. If any of the students missed classes, the SW and the DA come to our home"* [SN-G-FGD-TDS-PLW].

Monitoring appears to be more intense for TDS clients compared to PDS clients, with TDS respondents referring to a higher frequency of home visits. These visits seem to respond to an increased need for support following pregnancy or delivery rather than lack of compliance with co-responsibilities*: "The health extension worker and the social workers closely follow up on our kids as if they are their own. Especially the social worker visits us more than once a week time and sometimes every other day if a child is very sick. The health extension worker also visits us at least once per week"* [SN-G-FGD-F].

One group of male PDS clients also referred to the role of the kebele chairman in monitoring co-responsibilities, and school attendance for children in particular. The clients referred to a punitive approach, whereby the chairman would sometimes decide on 'penalties' for households in case of non-compliance: *"Mostly the health extension worker visits us and checks on latrine use and sometimes the chairman asks us about our life in general. The SW does come to our house more frequently than others. The chairman sometimes decides on penalties for not sending children to school for non-clients"* [SN-G-FGD-NonC-M]. Such penalties may be unrelated to the SCT programme and lack of compliance with co-responsibilities, but rather reflect the chairman's personal response to children not attending school.

The majority of clients – including the male PDS clients mentioned above – indicated that there were no repercussions from not complying with the co-responsibilities, other than the provision of advice: *"Nothing will happen, if we don't apply they advise us now and then"* [SN-G-FGD-PDS-F]. Such advice would be provided by the SW or HEW. The nature of such advice was not always considered entirely positive, however: "The HEW seriously tell us with anger: "*I am striving for your health, why have you missed your appointment?" in the meeting, if any of us does not have a latrine or is not using it, or is not using a bed-net. We are ashamed when we miss a single event"* [SN-G-FGD-F-PLW]. One female TDS client indicated that payment will be withheld when not complying with co-responsibilities, but she did not know of an example when this happened. She might have been referring to non-attendance of BCC sessions as part of PW rather than co-responsibilities for DS clients.

Service providers are all aware that the responsibility of monitoring and follow-up of co-responsibilities, including coordination with other service providers, is part of SWs' tasks. The SCT coordinator performs spot checks to check up on whether the SWs follow the right procedures: *"I […] select some cases randomly or deliberately select some special cases and pass through the whole process (identification to closing). Then after I gave technical assistance and feedback to the SW who manages the cases. To share the knowledge gained, I usually presented the process management results to all SWs in a way that they can learn from it and correct themselves"* [SN-G-KII-SCT].

In response to questions about implementation challenges, service providers raised concerns regarding the low number of SWs and their high caseloads. The SCT coordinator indicated: *"Since the number of SW are limited and one SW covers 6-8 kebeles, it is somewhat difficult to provide better services and continuous follow up"* [SN-G-KII-SCT].

6. Case management

Case management of PDS and TDS clients, beyond monitoring and follow-up of adherence to co-responsibilities, is another element of the IN-SCT pilot and part of the SW's tasks and responsibilities. When asked about case management, service providers did not generally distinguish this from regular monitoring and follow-up of PDS and TDS clients: "[Types of issues involved in case management are] *non-compliance, and cases that need special interventions like sexual violence, abduction, households affected by some accidents like burning of their house, and so on"* [SN-G-KII-SCT].

SWs and SCT programme staff provided various examples of case management of 'special cases', mostly in relation to child protection. Identification of such cases is done by SWs or by other service providers such as HEWs and subsequently referred to SWs. Cases are managed by SWs and may involve the SCT coordinator or other service providers. The SCT coordinator describes: *"The SWs identify the cases based on the information that they get from the service providers [...]. When there is a special case that needs group intervention, I personally engage in the case management process and try to solve their problems by mobilising resources and by communicating with the concerned individuals to be part of the solutions"* [SN-G-KII-SCT]. He indicated the case management process to work fairly well but that limited resources in terms of staff and transport limit their ability to address all issues and that the number of cases that can be responded to is limited to a handful

Two examples highlight the complexity of the cases and the need for collaboration between many stakeholders, including the police and judicial services, to provide an appropriate response.

A first example:

> *"5 months ago one girl was abducted in one of the kebele and hidden somewhere. The school director heard about it and immediately reported it to us, then we communicated with all the concerned bodies like women affairs, police office, woreda administration, etc. After 2 days of efforts, we got in the house where they had hidden her and got all the individuals who participated in the crime under control. We referred the case to the woreda judge, and the main actors are still in jail. The girl returned to school after she was given appropriate advice to be psychologically strong, since she was highly frustrated by the events that occurred."* [SN-G-KII-SCT].

A second example:

> *"A PSNP family had a daughter who was abducted at the age of 12, under a cultural practice where this entitled him [the abductor] to inherit the family's property. Later on a boy was born in her family who is culturally entitled and will inherit family's property. Then the man who abducted her returned her to the family, because he can no longer inherit the family property – girls do not inherit, but boys do. Now the girl is 14 years old and is back attending school. I made the matter public and am helping the family to seek justice and get compensation. Under Ethiopian law, this case constitutes rape as 18 is the legal age of sexual consent"* [SN-G-KII-SW].

7. Grievance mechanisms

This section explains how the PSNP-SCT grievance mechanism works, and how effectively it is working in practice, first from the service providers' perspective, then from the clients' perspective.

7.1. The grievance and appeal procedure

Every kebele has a **grievance committee**, which is led by the deputy chairperson of the kebele, and every woreda has an **appeal committee**, which is led by the deputy chairperson of the woreda. *"The community knows about the existence of grievance committees. Complaints are made in words or in writing to the chairman of the committee, who is the kebele vice-chairman"* [SN-G-KII-PSNP]. Most complaints are resolved by the grievance committee at the kebele level. If this is not possible, or if the complainant is not satisfied with the kebele committee's decision, the complaint is referred up to the woreda's appeal committee, which assesses the case and works together with the kebele committee to find a satisfactory solution.

> *"Upon receiving the grievance, the committee checks the appropriateness of the grievance response given to the client by the kebele committee. Then the woreda committee sends a team to the kebele to investigate the case. In some cases the woreda team invites the community to discuss the issue and to get their feedback before making a final decision"* [SN-G-KII-PSNP].

"The woreda steering committee and the food security unit of the woreda agriculture and rural development office are monitoring the grievance processes" [SN-G-KII-DA]. A woreda team typically comprises members from the Food Security, Social Cash Transfer and Disaster Risk Reduction units.

The SCT Coordinator identified a "design flaw" in the structure of the appeal committee in Girme kebele, in relation to the CCC.

> *"Sometimes there are errors committed by the kebele chairman, who also influences decisions made by the CCC since he is the chairperson of the CCC. Then the appeal committee usually faces challenges to change the chairman's decisions. I think it is design error. It should be studied and redesigned by changing the two committee chairpersons. It is better that the CCC is led by the deputy chairman of the kebele and the appeal committee is led by the chairperson."* [SN-G-KII-WSCT]

Social workers are not directly involved in the grievance mechanism. The social worker interviewed in for this study indicated to cover too many kebeles to be able to be involved; none of the other service providers or clients made reference to the social workers playing a role.

> *"During a visit by the regional ALSA and UNICEF, the Woreda LSA Unit was told to be involved in the grievance mechanism. But there is a grievance committee in every kebele and I cannot follow all 6 of them, so I am not directly involved. Clients do not come directly to me with grievances, because they have their own procedures at kebele level, but I go to the kebeles and sometimes hear these cases"* [SN-G-KII-SW].

7.2. Service provider perspectives

One social worker explained how the quotas imposed on client numbers could have excluded many eligible people, which might have been the basis for many complaints made to the appeal committees.

> *"During targeting there was a household asset registration, to identify who is really poor and eligible. I was there to verify whether the asset registration was done well or not. There is a*

quota for Public Works and a quota for Direct Support. This meant that many poor people were inevitably left out." [SN-G-KII-SW]

The targeting process was designed to be transparent and participatory, to minimise targeting errors and potential disagreement within communities. First the Kebele Food Security Task Force undertook a community wealth ranking and selected beneficiaries. Then the list was presented to the community for their comment. Next the kebele committee approved the beneficiary list, before submitting it to the woreda committee [SN-G-KII-DA].

Despite this transparent and inclusive mechanism, bias and nepotism was not totally eradicated from the beneficiary selection process. *"For instance, sometimes committee members would make sure their relatives and friends were included on the list, but the poorest were those who were left out."* [SN-G-KII-SW]

Most complaints or grievances are about targeting decisions. Some people who are excluded from the programme feel they should be included. *"Some of the households appealed by arguing that they fulfil the eligibility criteria of PSNP, but were not selected as a beneficiary"* [SN-G-KII-DA].

Sometimes clients who are placed on PW believe they should be moved to Direct Support – usually PDS – instead.

> *"For example, a household headed by a disabled person was targeted for Public Works, while exempting him personally from Public Works. The reason for targeting this household for Public Works was that other household members are of working age, but he complained that all his family should be moved to PDS. The grievance reached the woreda grievance committee, which assessed his complaint and found that both the targeting and the kebele grievance committee decisions were right. Finally, the woreda committee told the client that the decision by Kebele grievance committee and targeting were correct."* [SN-G-KII-PSNP]

Here is another example of a 'PW or PDS?' case that was resolved by the appeal committee.

> *"One old lady was targeted for Public Works, although she is old and has health problems, while another better off person – a man who can work – was targeted for PDS. In fact, this man had physical damage due to an accident. The woreda committee examined the old lady's appeal and found that she should be moved to PDS, while the man was moved to Public Works as he has recovered and can work."* [SN-G-KII-PSNP]

Other complaints were about the size of cash transfers received by clients. Since PSNP payments are calibrated by household size, many clients disputed the number of household members recorded at registration and requested larger payments. *"Most of the issues were related to their family sizes and the amount of payment they received"* [SN-G-KII-DA].

Specific procedural matters can also be taken to the appeal committee. For example, a compromise was found in a dispute about pay deductions for non-attendance at PW:

> *"Within the Public Works about 4 clients were not attending for about 5-8 days without sufficient reasons, so we deducted their pay for the days not attended. This was presented as an appeal to the kebele appeal committee and the issue went up to the woreda level. Finally, the woreda decided that the clients should work extra 'compensation' days, and the deducted money was paid in the next month"* [SN-G-KII-DA].

Occasionally complaints are of a more personal nature. For example, neighbours report PSNP clients who they believe are misusing their cash transfers, on alcohol or *khat.* Also, women who believe their

husbands are misusing the cash complain to the kebele appeal committee. *"In such circumstances the committee evaluates the appeal and shifts the cash transfer to women"* [SN-G-KII-PSNP].

Service providers believe that the grievance mechanism is a positive innovation, both for improved programme efficiency *("It helped to reduce mischief and bad governance like mis-targeting of ineligible households"* [SN-G-KII-PSNP-M]), and as a democratic tool that empowers poor people to claim their entitlements *("It ensures fair implementation of the project, created awareness on the rights of clients, and empowered the community to claim their rights"* [SN-G-KII-PSNP]).

Service providers did identify some problems with the grievance mechanism, and they offered some suggestions to improve its implementation. Some of the issues that prompt complaints are caused by programme directives that are beyond the mandate of the grievance committee to resolve – such as quotas on client numbers, or the '10% rule' for PDS clients. *"The number of PDS clients is limited to 10% proportion among the total PSNP beneficiaries. However there are so many beneficiaries who are eligible for PDS. Due to this direction given from the woreda, the appeal committee could not do anything to resolve some of these issues"* [SN-G-KII-DA].

According to this DA, the best way to manage such issues is more transparency and awareness raising: *"The procedures followed in selection, targeting and re-targeting of the beneficiaries should be transparent to the whole community members. If they know all the processes and issues their appeals will be minimised and the clients can be convinced in easily understandable ways"* [SN-G-KII-DA].

A final issue raised was the lack of documentation about complaints, which might be related to the slow process of establishing a computerised MIS.

> *"Due to the illiteracy problem, most complaints are made in words. The Kebele committee also processes the case and gives its response in words. As a result, no proper documentation is made of the issue for further engagement and follow-up. There should be proper documentation of issues, starting from application level through to the grievance handling process and decisions."* [SN-G-KII-PSNP]

Lack of documentation extends even to recording how many complaints are lodged with the kebele grievance committee. It was not possible to obtain an accurate figure for the number of complaints. One DA estimated that the kebele committee heard about 15 complaints and successfully resolved 13 of these. This number seems low, but the PSNP core process owner endorsed it: *"Complaints are very small as compared to the volume of the total PSNP4 beneficiaries in the Woreda"* [SN-G-KII-PSNP].

7.3. Client perspectives

All clients who were asked about the grievance mechanism concurred that it is possible to make a complaint about the PSNP or IN-SCT. Most said that the relevant person to complain to is the kebele chairman. *"If we have something we need to complain about, we go directly to the kebele chairman and complain to him and expect solutions only from him. We don't know any other mechanism"* [SN-G-FGD-PDS-F]. A few clients mentioned the DA as an alternative person to receive complaints. *"We can complain to the kebele chairman and sometimes to the DA"* [SN-G-FGD-TDS-PLW]. *"It is possible to make a complaint to the DA"* [SN-G-CS-PW-F].

Only one client interviewed was aware of the grievance committee. *"The grievance committee are the kebele chairman and spokesman, DA, health worker, school director, elderly man, and religious leader. We mostly complain to the chairman, who is the head of committee"* [SN-G-FGD-PW-M].

Several clients said that they have never made a complaint about the PSNP or IN-SCT. *"I have not experienced any problem before, so I never complained"* [SN-G-CS-TDS-PLW]. But others reported on complaints they have made and the response they received (see Box 2).

Box 2.   Client experiences of appeal mechanism
"Some 3 or 4 months ago the cash transfer was delayed due to unknown reasons. So we complained to the DA and kebele chairman. The chairman and DA immediately communicated with the concerned individuals at woreda level and we were paid after two days of the complaint." [SN-G-FGD-TDS-PLW]
"At the beginning of this year 50 birr was deducted from my transfer. So I asked the OMO MFI person why this has happened. He told me that it was saved for me but I didn't agree because they didn't have a receipt. I did not believe them. Then I went to the kebele chairman and informed him about my case. The response was fast. After the kebele chairman discussed with the OMO MFI person, they gave me back my money." [SN-G-CS-PW-M]
"Most of us complained to the kebele chairman, as we were benefiting for 2 or 3 family members, however our family size is beyond 5. The chairman responded that it is because the number of PSNP beneficiaries increased over time and the government allocated only some amount of budget which can't cover all individuals' problems. Therefore they shared the available resources to the most affected households, by minimising the number of beneficiaries within the households. What shall we do? we simply heard his justifications and kept silent." [SN-G-FGD-PDS-F]
"I complained about targeting. I have nothing in my house and I am chronically food insecure but I am not included in the programme. I first complained to the men's development group leader in my village who knows my economic status very well. He told me that he included me in the programme, but after a while I knew that I was not included and I asked the leader "why?" He replied that "I included you but the chairman cancelled you". Then I complained to the chairman and he told me to come with the village group leader. But he refused to go to the chairman with me. I reported this to the chairman and complained again and again, but no response. Finally, after several attempts I was fed up and kept quiet. I was left without a timely and adequate response from the chairman." [SN-G-FGD-NonC-M]

The first two of these four cases appears to illustrate a satisfactory response to grievances. Respondents whose payments were either delayed or illegitimately reduced complained to a person in authority – but not necessarily to the committee – and their problem was resolved, promptly and satisfactorily. The third case illustrates how the grievance mechanism is responsive but does not necessarily resolve the issue in the complainant's favour. (In this case the complaint was legitimate, in the sense that clients were being paid less than their entitlement, while the response reflected the reality of budget constraints and quotas.) The fourth case reflects a dysfunctional grievance mechanism. Whether the excluded non-client had a valid case for inclusion or not, he deserved a fair hearing and an explanation, which he never received despite making repeated attempts.

It might be that local authorities were overwhelmed with complaints from excluded non-clients and could not cope with them all, but it is also possible that non-response reflected incentives to conceal nepotism or corruption in the client selection process. This possibility is evident in this remark by another excluded non-client: *"The village group leader is better than me in any economic measure, and yet he is a PSNP client"* [SN-G-FGD-NonC-M]. This also resonates with the observation made by a social worker, quoted above, about "relatives and friends" of committee members appearing on client lists ahead or poorer households.

Not surprisingly, clients whose complaints were resolved to their satisfaction are happy with the grievance mechanism and have no suggestions for improving it. By contrast, clients (and non-clients) who were not satisfied with how their complaint was handled seem to be unaware of other structures beyond the kebele chairman or local DA that they could appeal to – notably the woreda-level appeal

committee. *"We do not know what to do, but government should look in to our complaints and make the kebele people accountable for not responding"* [SN-G-FGD-NonC-M]. This constitutes a serious gap in awareness that needs to be filled urgently, if the accountability and effectiveness of the grievance mechanism are to be strengthened.

8. Social services

The theory of change of the IN-SCT and its success crucially hinges on collaboration between service providers in a bid to provide a comprehensive set of services to clients. Key actors on the ground include the SWs, HEWs, DAs, school directors and teachers and the CCCs. At woreda and regional level this requires collaboration between representatives of the labour and social affairs, agriculture, health and education sectors. SCT steering committees at woreda and regional level act as formal mechanisms for supporting such collaboration (Schubert, 2015). SCT secretariats at woreda level – located within in WoLSAs (or in the case of SNNP, in Woreda administrations) – are responsible for daily implementation of the programme, including the collaboration with other service providers.

8.1. Social Workers (SWs)

Discussions with PSNP clients highlight the wide range of services that they receive from the SWs.

PDS clients referred to receiving home visits during which issues related to education, health and sanitation are discussed: *"He visited us at home and asking how much money we received, do our children properly attending schools or not, and advise us to take care of our health and to get food on time"* [SN-G-FGD-PDS-F]. Discussions with PDS clients also indicate that they received financial support, which appears to be provided by the SW him/herself: "*He gave some of us cash (e.g. 100 birr for participant) to buy exercise book and pencil for our children"* [SN-G-FGD-PDS-M] and *"My child was abducted and forcefully married, he followed up and supported me to get her back to school and provided me 400birr in support from his pocket"* [SN-G-FGD-PDS-M].

TDS clients also referred to receiving home visits from SWs and receiving advice on nutrition, hygiene, health and school enrolment. Caregivers of malnourished children receiving TDS also indicated that the SW undertakes case management, i.e. overseeing the compliance with co-responsibilities. One female TDS client (PLW) indicated:

> *"He visits me at my house and gives me different advises like sending all children to school, properly following-up antenatal and postnatal care, keeping house and personal hygiene and sanitation, using toilet and mosquito net, properly using the PSNP cash and if possible saving, strongly engaging in agriculture for good harvest. He checks that children are at school on their attendance"* [SN-G-CS-TDS-F].

PW clients discussed the SW's role in providing advice about and monitoring the shift from PW to TDS for PLW, in supporting the BCC sessions that are provided to PW clients, among others. Female PW clients indicated: *"The SW notifies us about our rights and duties in the PSNP. He told us to tell the DA or HEW when we are pregnant to be transferred from PW to TDS starting from our fourth month of pregnancy until the child is one year old. He also told us to bring our children to health post for vaccination; and advised us to send children to school"* [SN-G-FGD-PW-F]. Male PW clients reported: *"He supervises transfer of PLW to TDS and advises us its proper use. He supervises whether children below 18 years and PLW engagement on PW, if he find them working he told them and the foreman prevent them. He also supervises BCC session by service providers (DA, HEW, school)"* [SN-G-FGD-PW-M].

Non-clients indicated that they don't receive any direct support from SWs but that they frequently observe SWs undertaking their work in their communities and visiting PSNP clients as well as other vulnerable community members. Non-clients indicated that although they don't often have direct contact with the SWs, they feel that the support provided by SWs is beneficial for the community at large: *"Even though [*they do not provide support] *directly to us, […] he is coming to our kebele*

frequently. The social worker provides advice to all community members about sending children to school, on supporting each other on agricultural activities (especially on backyard gardening), and supporting elderly and disabled persons living in our kebele" [SN-G-FGD-NonC-M].

The large majority of PSNP clients are positive about the support provided by SWs. They are now aware of their rights and responsibilities within PSNP, as voiced by female TDS clients: *"We know our rights and responsibilities, and about being privileged to transition to TDS"* [SN-G-FGD-PDS-F]. Female PW clients also provided an example of their increased knowledge of procedures following support by the SW:

> *"He helped us to know our rights and responsibilities in the PSNP and enabled us to ask for our rights confidently. After his intervention in our kebele, all pregnant PW women have started transferring to TDS because he came to PW place and checked if there is any PLW women in the PW place. He made follow up every time. Now we also know that we are required to work on PW activities less hours than the men counterparts to have more time for other household activities"* [SN-G-FGD-PW-F].

Others commented on the nature of the support and its social effects. As indicated by female TDS clients: *"he always follows up and encourages us. He does his job very efficiently and motivates us by considering all children as his own and in a very sociable manner"* [SN-G-FGD-TDS-F]. Male PDS clients highlighted how the involvement of SWs makes them feel acknowledged by government: *"we think that now government remembered us a citizen and our confidence has improved"* [SN-G-FGD-PDS-M].

Some clients indicated that they would like to receive more frequent visits from the SW and believe that this will improve outcomes further: *"If possible we need his frequent visit"* [SN-G-CS-PDS-M]. The female PW client group pointed out that visits to the kebele are not as frequent as is desirable, but that they are aware that this is because of the SW's heavy workload: *"He is very good and cooperative person. But he doesn't come to us frequently as he told us he has a lot of responsibilities with PDS and TDS clients in this kebele and in other kebeles"* [SN-G-FGD-PW-F].

Various service providers highlighted that SWs may not be appropriately aware of the local context and local languages, creating a distance between the SW and the clients: *"Most of the social workers came from other areas, and thus they couldn't communicate well with the community due to the language barrier and faced difficulties adapting to this environment"* [SN-G-KII-WoLSA].

When asked about how the support from SWs could be improved, some respondents pointed out that SWs should be given more support and greater incentives for their valuable work: *"Government should award and motivate employees like [SW] who tirelessly supports all of us. Even if it may be difficult for government to give him a vehicle, he deserves more than a motorbike and needs to be promoted"* [SN-G-FGD-NonC-M] and *"He needs to get promotion or something that encourages him to work for long with our kebele"* [SN-G-FGD-TDS].

8.2. Health Extension Workers (HEWs)

All PSNP clients and non-clients that were interviewed reported on services that they had received from the HEW over time. This ranges from advice about nutrition, hygiene sanitation at the health post or at home, vaccinations, antenatal and postnatal care to BCC sessions. A female TDS client (caregiver of malnourished child) provided the following account:

> *"She teaches us about hygiene and sanitation and always tells us to keep our house and body clean, to do hand washing before eating and after toileting. […] She provides regular vaccines for children and also campaigns for some diseases. She provides nutrition education, supplementary food for*

malnourished children and follows up on them. Shows us how to prepare enriched food for children. Malaria protection- she advises us to clean our surrounding and utilise mosquito net during night especially when pregnant and for kids. Advises us to properly feed other children too." [SN-G-CS-TDS-F]

Male PW clients reported on the various locations where the HEW performs her tasks: *"She is teaching us on the PW site [BCC session], at health post for PLW and through women development army [1:30 group] leaders meeting sessions"* [SN-G-FGD-PW-F]. Female non-clients also indicated that the HEW makes frequent home visits to households with malnourished children*: "She makes home visit once a week to identify malnourished children"* [SN-G-FGD-NonC-F].

All answers appear to conflate services that are provided in general and as part of the IN-SCT pilot. Respondents were asked about the services that they receive from HEWs and no one explicitly differentiated between services that have been in place for a long time and new support (or intensification of support) that has come into place after the start of the IN-SCT.

All respondents pointed out that the support provided by HEWs has been greatly beneficial to the situation with respect to health, nutrition and sanitation. This ranges from having better knowledge about good practices, more households having pit latrines to a larger proportion of women having safe deliveries.

PSNP clients and non-clients raised a number of challenges with respect to the support provided by HEWs and the extent to which their support can be translated into better outcomes.

Firstly, some respondents indicated that the HEW is not able to undertake frequent visits due to transport issues*: "The health extension worker does not frequently visit far households because of transportation problem"* [SN-G-FGD-PW-F]. There was some confusion over how many HEWs are currently serving the kebele with male PDS clients indicating that the HEW cannot make frequent visits as she is the only one present in the kebele but male PW clients explaining that a new HEW is now also present: "She is coming to us less frequently (once per month) as she is the only person in the kebele: "*Up to last year, only one HEW was working in the Kebele. She was over burden to cover the entire Kebele. Consequently, took long time to be visited and sometimes she was not covering the entire area. But now after assignment of additional HEW, we are getting adequate service"* [SN-G-FGD-PW-M].

A second challenge pertains to lack of supplies. Many respondents pointed out that the HEW often lacks appropriate medical supplies in the health post to respond to health issues: "[she has] *no supplies of medicine even for minor illnesses such as malaria, headache etc."* [SN-G-FGD-NonC-M]. Inadequate supplies of supplementary feeding was also mentioned as an issue: *"There is shortage of supplementary food at health post"* [SN-G-CS-PW-M].

Thirdly, respondents referred to the lack of capacity on behalf of the HEW to provide a proper diagnosis or respond adequately. A non-client provided an example from own experience: "*the services she is providing is limited [...]. She cannot provide support to disabled children, even linking with other institutions that support deaf students"* [SN-G-FGD-NonC-M]. Female non-clients indicated: "*We have problem when we are sick as the health extension worker can't identify our health problem or disease most of the time"* [SN-G-FGD-NonC-F].

Finally, some TDS clients indicated that they are unable to act on the advice provided by HEWs due to financial constraints: *"due to resources problem I am not strictly following the nutrition education. I wish to cook and feed good food to all of my children particularly for the babies but I don't have money to buy the different materials like egg, vegetables and fruits"* [SN-G-CS-TDS-PLW] and "*Some of her*

advices and education are not fully accepted by me and other women such as personal hygiene due to absence of cash to buy soap and clothes to change that hinder washing clothes" [SN-G-CS-TDS-F].

Notwithstanding these challenges, respondents were highly appreciative of the work provided by the HEW. One of the respondents in a male group of non-clients used a local saying to express her character: *"Yemitnitew wotet yelat, le kibie maskecha tasebalech".* This translates as "she who has no milk, worries about the butter container", meaning that although she has her problems (like lack of transport facility) she always gives priority to community's needs and thinks about long-term change in the community.

8.3. Development Agents (DAs)

All respondents refer to services received from DAs. This refers mostly to agricultural activities, either related to PW or more generally. Male PW clients provided a comprehensive account of the support provided by DAs in their kebele:

> *"There are 3 DAs in the kebele who work in one village (goati) each. The DAs give us extension service through field and home visits, demonstration at FTC [Farmers Training Centre], and BCC secessions at PW site. The extension and education service we get from DAs are on agricultural practice like repeated ploughing, proper weeding, row planting, crop-rotation, fencing farmlands adjoining pathways (road), proper fertiliser dose and type. Previously our crop was damaged (eaten) by livestock, particularly on farmland located adjacent to road (pathway) but due to fencing as advised by DA, crop damage by livestock is avoided. Row planting and planting at required rate improved yield, previously we were overplanting, which resulted in stunted crop and thereby reduced yield. We got accustomed to plant even small crops like teff, wheat and finger millet besides, maize and sorghum. The DAs also teach us on crop diversification (planting fruits, vegetables and cash crops besides cereals and leagues); saving livestock feed for dry season and planting improved livestock feed/forage; maintain number of livestock proportional to available feed (destocking); implementing soil and water conservation practicing on farmlands and the like. Fungus also major problem which infect the entire farmland if no proper action on time, DAs advised us to supervise our farm and uproot if appeared in the farm, this helped us to control the dissemination of fungus, particularly for maize and sorghum."* [SN-G-FGD-PW-M].

PDS clients also reported receiving advice with respect to planting and use of seeds and fertilisers. They also refer to natural resource management: *"He teaches on types of fertilisers and when to apply them for specific crops. Additionally, the DA teaches and shows preparation and application of organic fertiliser (compost)"* [SN-G-FGD-PDS-M] and *"Mobilises community for flood diversion and natural resource management"* [SN-G-FGD-PDS-M]. It should be noted that the male PDS clients provided more elaborate responses to questions about services received by the DA compared to female PDS clients.

Responses by TDS clients are in line with those provided by PDS clients: "*He conducts demonstration at FTC and teaches us about agronomic practices (e.g. row planting)"* [SN-G-FGD-TDS-F]. A few TDS clients also referred to the DA's role in the transition from PW to TDS, in this case for caregivers of a malnourished child: *"He made my transfer to TDS possible by working with the HEW and also follows up on my malnourished kid with HEW and SW"* [SN-G-CS-TDS-F].

PW clients also emphasised DA's support regarding knowledge and technical advice regarding agricultural practices, and also highlighted that the DA provides wider advice about children's wellbeing: "*He teaches us about row planting, land preparation, ploughing by conducting demonstration at FTC. […] He advises use about improved farm inputs such as fertiliser and improved*

seed, visits us at our farm during planting season, and advises us about crop rotation and pond construction. Also he advise us to send our children to school" [SN-G-CS-PW-F]. The DA also provides advice regarding participation in PW activities: "*He advises us to properly attend public work activity in order to receive our transfer regularly*" [SN-G-CS-PW-M].

All respondents indicated that the DA's support has been very helpful in increasing knowledge and improving agricultural practice, leading to improved outcomes. Female TDS clients (PLW) also reported that the support of the DAs has ensured a smooth transition from PW into TDS: *"They facilitated the transfer (from PW to TDS) process quickly"* [SN-G-FGD-TDS-PLW].

Respondents held mixed opinions with respect to any challenges in relation to the support provided by DAs. Roughly half of the respondents did not report any significant challenges. Others raised issues that may undermine the support provided by DAs or the extent to which it can be translated into better outcomes.

A first challenge refers to geographical spread of households within the kebele and the inability to cover all households on a regular basis: "*He does not visit far-away villages in the kebele unless there are PW activities. This created differences in agricultural improvements among villages* [SN-G-FGD-PDS-M]. Female TDS clients indicated that they think it is linked to a lack of motivation: *"Some villages are far from the kebele centre and are not well served as other DAs are not equally motivated. He mostly stays at and in villages closer to the kebele and FTC office*" [SN-G-FGD-TDS-F].

A second challenge reflected an inadequacy of the types of support that were provided: *"Sometimes it is only theoretical education and important skills are not provided by the DA, and flood is not taken seriously in PSNP PW activities. That is our critical problem to get food from our small land as the only source*" [SN-G-CS-TDS-F].

There were mixed reports from across respondent groups in terms of distribution of inputs. Non-clients complained about PSNP clients being prioritised, leaving other vulnerable community members left out: "*PSNP beneficiaries are given priority for distribution of seeds of some crops such as Teff and fruit tree. However, there are also some peoples who are very poor like PSNP clients in this kebele who are not included in PSNP. So this people should be under consideration at least when seeds are distributed for free* [SN-G-FGD-NonC-F]. At the same time, TDS clients (PLW) complained of not receiving adequate supplies: *"improved seed and poultry (i.e. small chicks) were not adequately supplied to us"* [SN-G-FGD-TDS-PLW].

8.4. Overall collaboration

Programme staff at regional, woreda and kebele level were asked about the overall collaboration between providers with respect to programme implementation. All staff at woreda and kebele level were positive at large, highlighting greater levels of collaboration in comparison to the situation prior to the implementation of the IN-SCT and more opportune division of tasks and responsibilities.

The WoLSA SP core process owner and SCT coordinator highlighted the important role of the steering committee in fostering effective collaboration: *"We are working in a well-organised way and with good collaboration. All main stake holders are striving to play their roles; since the woreda steering committee is actively evaluating the project progresses as those main stakeholders' office heads are members of the steering committee, they are always alert to act"* [SN-G-KII-SCT].

The PSNP coordinator and SCT coordinator explained the functioning of the steering committee:

"We are collaborating with different offices, the offices working together in PSNP4 and IN-SCT include: BoA, BoLSA, BoE, BoH, Women and Children Affair, Youths & Sport and Woreda Administration Offices. The collaboration is mainly on service linkage, service provision, reporting and beneficiary targeting" [SN-G-KII-PSNP].

"The committee meeting is at least once in a month, and evaluates the progress of the project implementation. I always present the brief progress reports and the problems we faced during implementation. The committee members exhaustively discuss and every sector heads took his/her own assignments to solve the raised problems" [SN-G-KII-SCT].

In a discussion with SCT steering committee, members voiced the importance of cross-sectoral collaboration and the importance of the committee in fostering this: *"This committee is so relevant and creates additional opportunity for discussion about sectoral gaps and progress towards common goal of solving social problems"* [SN-G-FGD-SCT]. The DA highlighted that actual integration of support is mostly visible at kebele level: *"More of the integration is visible at kebele level between DAs and HEWs, HEWs to SW and DA with SW. I think at woreda level they are working through steering committee"* [SN-G-KII-DA]. Indeed, the regional SCT coordinator highlighted that collaboration with HEWs has markedly improved since the start of the programme, mostly as a result of training: *"Some of the challenges at the beginning included lack of commitment from HEWs but they have now started to consider the programme as part of their duty since training provided by Woreda Health office on PSNP4"* [SN-KII-SCT].

Programme staff were also positive about the positive effects of the cross-sectoral collaboration on clients. The HEW highlighted: *"Yes, the collaboration between kebele manager, SW, school director and DA led to improved school enrolment because of the awareness given by all these stakeholders, and the co-responsibilities and case management contributed to improvements in education"* [SN-G-KII-HEW]. The DA offered a similar opinion: *"Yes they have high contributions. They are working together, when the problem arises they tried to solve timely, shared information one to another to make informed decisions. There are visible improvements in school enrolments, school attendances, and the clients are getting different health services like ANC, PNC, immunisation, etc."* [SN-G-KII-DA].

The CCC members provided a more detailed account of the benefits of collaboration:

"The collaboration is very good. They are helping each other during home visits. One service provider handles all cases (health, education, agriculture) in a village/home visit. Unlike the previous time [before PSNP-4], we are working in collaboration and in coordinated manner. For example, if teachers go to a student's home in case of providing advice following dropout or being absent, […] he/she consult the HH and resolve the problem or advises them to visit HEW or DA" [SN-G-FGD-CCC].

8.5. Challenges

Notwithstanding the positive experiences with collaboration across services and its positive effects, programme staff and service providers also discussed various challenges, ranging from issues regarding higher-level management to frontline programme implementation.

Various challenges were mentioned with respect to the functioning of the SCT steering committee and collaboration between stakeholders at woreda level. The SCT coordinator referred to issues relating to **staff turnover**: *"The major challenges we usually faced on this regards is there are frequent shifting of the office heads that makes strange until the newly appointed person knows about the project in details"* [SN-G-KII- SCT]. Members of the SCT steering committee highlighted that the committee lacks

a clear TOR to support its functioning and also flagged that collaboration can be undermined by many other **conflicting duties and responsibilities**: *"Sometimes there is a loose collaboration due to overlap of duties/meetings and urgent assignments"* [SN-G-FGD-SCT].

The constraints posed by conflicting duties and responsibilities in conjunction with high workloads were raised as an issue undermining collaboration at community level. The SW said: *"Collaboration could be improved if there was quick response from other service providers. The woreda administration also needs to put in place more DAs and more HEWs and more SWs. This would also improve the functioning of the PSNP"* [SN-G-KII-SW]. An insufficient social workforce was also mentioned by the regional SCT coordinator as an obstacle to effective collaboration.

The SCT coordinator indicated that collaboration between those implementing the programme on the ground could also be improved by introducing a meeting with frontline workers: *"Besides the steering committee, it is better to have a technical working group at woreda level formed from main stakeholders at experts' level who can play significant roles at operation level for better works in more integrated manner and feed basic information to the steering committee to make informed decisions"* [SN-G-KII-SCT]. The DA also raised the need for greater integration through meetings: *"Better integration and continues review meetings in which all stakeholders can be evaluated and corrected themselves time to time"* [SN-G-KII-DA].

Collaboration between service providers at community level (as well as programme implementation in general) was reported to be undermined by the vast areas to be covered and subsequent logistical constraints: *"The size of the woreda is very big, so it is very challenging to reach remotely located kebeles, we have to drive over 80 km on poor road to reach the farthest kebele"* [SN-G-KII-PSNP].

8.6. Collaboration between MoLSA and MoARD

A particular collaboration of interest is the one between labour and social affairs and agriculture given the shift of responsibility for implementation of Direct Support away from agriculture to labour and social affairs.

The regional SCT coordinator explained the process of transition and the important role of the IN-SCT pilot in informing this process:

> *"At the regional level, ALSA[7] is working with FS* [Food Security] *on PSNP4 with special focus on the smooth transition of Direct Support on which the IN-SCT is informing us that it is possible for the labour and social affairs sector to manage the administration of PDS clients. Among others, some of the major activities include: 1) Memorandum of Understanding (MoU) is to be signed between the two sectors at regional level; 2) ALSA is working as member of Regional PSNP planning coordination team; 3) Consultation workshop held where regional & zonal officials were able to discuss together as partners on PSNP; and 4) Capacity building trainings being provided for ALSA staffs at all levels. This has been highly attributed to the fact that IN-SCT pilot is informing all actors about the optimistic successes underway in the two woredas. The cross-sectoral collaboration horizontally and vertically, at woreda, regional and federal levels is increasing from over time. Most importantly, close collaboration and working partnership is established between WoLSA and woreda Agriculture/ Food Security office"* [SN-KII-SCT].

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[7] The regional office for the Ministry of Labour and Social Affairs (MoLSA) is a unit – Agency of Labour and Social Affairs (ALSA) – rather than separate bureau – Bureau of Labour and Social Affairs (BoLSA) – as in other regions.

Collaboration between SCT designated staff (i.e. SCT coordinator, SWs and MIS focal person) and PSNP (PSNP coordinator and DAs) staff seems to be working well, according to self-reported responses to the questions: *"How do you collaborate with the PSNP coordinator? How do you collaborate with the WoLSA SP core process owner and the SCT coordinator?"*

> *"We are working together as one body. I myself and all social workers involved in the beneficiary selection and re-targeting processes – wealth ranking assessment, technical assistance on its analysis – capacity building interventions such as trainings and monitoring activities. We are also working very closely with other staff and PSNP task forces at woreda and kebele levels."* [SN-G-KII-WSCT]

The transfer of responsibility for Direct Support beneficiaries from Agriculture to Labour and Social Affairs had the potential to create many transitional problems, but one WoLSA staff member refuted this concern, explaining that WoLSA and the Bureau of Agriculture are doing many activities jointly, at both the woreda and kebele levels, from targeting to monitoring service delivery:

> *"As WoLSA is newly engaged in PSNP we are working together in many activities like targeting, re-targeting and cash transfers. Initially BoA fully carried out beneficiary targeting – both PW and PDS – and we conducted re-targeting and facilitated cash transfers jointly, for both PW and PDS. We also collaborate in follow-up of service provision by kebele offices of health, education and agriculture. The regional Finance Office sends the money for both PDS and PW together to one account, this shows our joint engagement in cash transfers. The payment is effected through e-payment system through OMO agents, so when any problem happens on payments we solve the issue jointly. Similarly, our structures at kebele level (DAs and SWs) are also working together."* [SN-G-KII-PSNP]

The PSNP coordinator highlighted that a strong collaboration already exists and indicated that the shift in responsibility for Direct Support has been beneficial for the spreading of workload: *"Our collaboration is good. BoLSA is handling PDS and TDS cases, which reduced workload on our office which helped us to focus on PW. We work as a team, especially during field monitoring. We are also sharing resources (logistics) and collaborating in training. DAs and SW are also working together"* [SN-G-KII-PSNP].

One practical example of positive collaboration was provided by a WoLSA SP core process owner, who responded to complaints from PSNP clients who felt they were being graduated prematurely, by taking this issue to the PSNP coordinator and agreeing together on a way forward:

> *"Within this month I met with him one time and discussed about the PSNP clients' graduation issue. The initiation was a group of individuals who came to my office and claimed that: "The PSNP office is forcing us to graduate from PSNP support, but we are not fulfilling the criteria to be graduated". I took their claim and discussed it with him and found the appropriate solution."* [SN-G-KII-WoLSA]

Other respondents highlighted challenges with respect to the collaboration. The regional SCT coordinator mentioned the *"lack of willingness or the so-called resistance from Food Security to effect the smooth transition of PDS to ALSA"* [SN-KII-SCT] as one of the barriers.

A social worker explained how there is no separation of functions at woreda level in Girme woreda, because there is no WoLSA, only a unit where all those involved in the PSNP and SCT work together:

> *"Here Labour and Social Affairs is a unit under the Woreda administration [ALSA] rather than a separate bureau [WoLSA]. As such there is no WoLSA SP core process owner. I am working more*

closely with the SCT coordinator, who is directly appointed to the unit head. We work all together – there are no separate sub-units within this office.” [SN-G-KII-SW]

The DA highlighted how ineffective collaboration between agriculture and labour and social affairs undermines programme implementation and negatively impacts PSNP clients:

“Cash payments are usually delayed up to 2-4 months, though we always submitted the PW attendance list timely to the woreda agriculture office (from 21st to 23rd of the month). Mind you the clients are very poor; they are not capable to fill the food gaps of their households beyond this payment. The delay increases their suffering and thus it hinders the project outcomes. We asked the concerned bodies in the woreda about this issue but no one has given appropriate response. I think it may be due to the transition of PDS management from agriculture office to WoLSA” [SN-G-KII-DA].

8.7. Collaboration with Concern

Concern's role within the IN-SCT is to support the provision of nutrition-sensitive interventions, including supporting cooking demonstrations, setting up nutrition clubs, promotion of school gardens and supporting Farming Training Centres (FTCs). The Concern project coordinator in Halaba summarised the NGO's role in the implementation of the IN-SCT as follows: “*The first component of our project is to improve health and nutrition uptake of PLW. Second one is to support the children under five to get diversified meals. The third one is related to adolescents and to improve nutritional messaging for adolescents*” [H-KII-Concern].

Concern's Health and Nutrition Coordinator in Addis Ababa described activities that were undertaken in more detail, highlighting their collaboration with government partners and UNICEF:

“We have our own supervisors that we hire through this project. We use a cascading model for delivering BCC materials. BCC materials were initially developed by UNICEF and we reviewed those and piloted them. […] We went to Halaba with UNICEF to provide TOT to WFSTF and social workers from WoLSA and DAs and also HEWs. This will be cascaded down to kebele level through KFSTF. […] We set up FTCs with Buy Economy Africa and tasked them to rehabilitate 8 FTCs in Halaba and Shashego that already existed under Agriculture. This includes bee-keeping, poultry farming, gardening with the main target to increase dietary diversity and promote backyard gardens. We only do rehabilitation but it is all run by Ministry of Agriculture. Concern provides seeds and saplings for vegetables and fruits so that there is no barrier in terms of inputs. You need a strong presence in the area to start new things. […]We establish nutrition clubs. UNICEF are providing different types of BCC materials. We received TOT training from UNICEF and we are providing training to staff in 40 schools and planning to scale to 80 schools.” [KII-Concern]

Both the coordinator in Addis Ababa and the project coordinator in Halaba indicated the work to be largely progressing in line with the agreement with UNICEF: *“Regarding actual implementation, we are working very well. We are almost on the way to complete the first component”* [H-KII-Concern] and *“We think that the results will be as expected and we hope that it will be scaled up”* [KII-Concern].

Both coordinators also pointed at challenges and delays: *“The third component was delayed due to various issues”* [H-KII-Concern]. These issues included **external factors** such as severe floodings in the first half of 2016 and issues with the security situation in the second half of 2016 as well as **logistical and administrative issues** such as delayed receipt of training packages from UNICEF, conflicts with teachers regarding the per diem amounts to be provided during trainings, which they considered to be too low and transportation constraints due to having too few motorbikes. The national Concern

coordinator also referred to the **challenges of collaborating with local government partners and communities**, particularly given the many pressures and commitments on behalf of such partners and communities: "*Commitment of local government and communities [is a challenge], which can be due to challenges that they face. This includes drought and floods and also their own harvest activities. They have reservations to participate when they are busy. Authorities may also not be able to offer a lot of support due to other political commitments*" [KII-Concern].

Although respondents were not specifically asked about their engagement or experiences with Concern staff but discussions with service providers in particular did highlight some of Concern's inputs into the programme and their benefits, particularly in providing support to ongoing elements of PSNP programming. As indicated in section 3.1, Concern is represented in the Woreda Steering Committee, embedding them in implementation of the IN-SCT. The HEW describes how Concern's inputs with respect to cooking demonstrations lead her to provide separate BCC sessions for PLW that are PSNP clients. She is used to organising BCC sessions to all PLW in the community but Concern provides specific support to sessions targeted at PLW that are part of PSNP:

"*The BCC sessions here are given at health post once a month to all PLW in the kebele in collaboration with mothers' network (1 to 5) but the difference [for PSNP PLW] is with the help of an NGO called concern. I give awareness on nutritious food preparation by demonstration only to PLW PSNP beneficiaries. The NGO provides me all the different food and equipment required for cooking demonstration and that is a reason for provision of specific BCC session for PLW that are PSNP clients.*" [SN-G-KII-HEW]

The regional SCT coordinator provided an example of how the input by Concern has helped to improve collaboration with HEWs: "*Absence of organised family folder at the health posts was also the other challenge [with respect to collaboration]. This is also solved by the involvement of woreda health office and family folders further improved as Concern World Wide posted a sticker (PSNP) on the family folders of clients*" [SN-KII-SCT].

These findings echo the perspectives of the national Concern coordinator in Addis Ababa regarding their role in the programme and the collaboration with government partners: "*We play a catalytic role. Our presence is not directly visible on the ground. [...] It is through the existing government system that Concern works*" [KII-Concern]. This emphasis on playing a catalytic role rather than serving as a key implementer makes it harder to assess the extent and impact of Concern's work.

8.8. *Sustainability of collaboration*

In response to questions about long-term feasibility of collaboration between service providers, respondents pointed at the strengths of the current collaboration as well as challenges for the longer term future. The HEW pointed out that cross-sectoral collaboration already existed prior to the IN-SCT but that the pilot has helped to strengthen it. SCT committee and CCC members indicated the current levels of integration serve as a strong foundation for sustaining future collaboration: "*In our assessment the collaboration is improving through time, it will grow to institutional level*" [SN-G-FGD-CCC] and "*Though it is a pilot and short time we are feeling that coordination is resulting in good results on the community and definitely will lead to longer term changes*" [SN-G-FGD-SCT].

Challenges as mentioned by the respondents include **government ownership for social workers** and **high staff turnover**. The SCT coordinator stressed that the government must take over social worker activities to ensure sustainability. The DA mentioned: "*In my opinion those providers will continue to work together, but the staff attrition may affect the collaboration between the service providers unless continues orientation given to the newly assigned staffs*" [SN-G-KII-DA].

9. Community Care Coalitions (CCCs)

Community Care Coalitions (CCCs) are considered to play a vital role in implementation of the IN-SCT and facilitating linkages to services at community level. The Manual of Operations states that members of the CCC are to support the SWs with home visits, to provide advice to clients about co-responsibilities and to follow up in case of non-compliance. The provision of case management of PDS and TDS clients beyond co-responsibilities as well as the provision of wider assistance to vulnerable households is also part of their tasks. CCCs include representatives from across the kebele, including the chairman and members with a direct role in the IN-SCT pilot such as school directors or teachers (Schubert, 2015).

The SW explained the functioning of the CCC in relation to the IN-SCT pilot, which are in line with the tasks and responsibilities as outlined in the Manual of Operations:

> "There is a CCC in each of the 6 kebeles in this woreda, and they are functioning well. Their key roles are (1) they make linkages with the communities very easy, because they know who is who, (2) the CCC brings together the key stakeholders for the project, since they are members, (3) the CCC also accompanies the SW/ DA/ HEW on field visits to address issues like failure to comply with co-responsibilities." [SN-G-KII-SW]

The SCT coordinator and CCC members indicated that the CCC had also been part of the targeting and beneficiary registration processes and are take part in checking clients' compliance with co-responsibility.

9.1. Service provider perspectives

Many programme staff indicated that CCCs play a vital role in programme implementation. The SCT coordinator said: "*CCC […] facilitates the service providers' integration to have better linkages and giving appropriate responses for non-complaints*" [SN-G-KII-SCT]. Beyond the provision of advice to support compliance with co-responsibilities, CCC members may also mobilise resources for overcoming financial barriers: "*We also get involved when PDS households face problems to cover educational material costs for their children. In such cases, we mobilise resources (grain and money) from community through school*" [SN-G-FGD-CCC].

The SW provided an example of how the CCC provides support beyond implementation of IN-SCT: "*The CCCs also mobilise support for poor people, like providing labour to construct or maintain housing for people who lack labour capacity to do this themselves*" [SN-G-KII-SW]. This was corroborated by CCC members: "*We support PDS households in different problems like supporting them maintaining their house, cultivating their farmlands and helping them in weeding and harvesting through community mobilisation*" [SN-G-FGD-CCC]. They were also involved in the case management of the two child protection cases mentioned in section 6 above. CCC members indicated that they primarily support PSNP clients but sometimes extend support to non-clients if possible.

Responses do suggest that performance of CCCs may differ across kebeles: "*in some kebeles like Girme they are actively working and have contributions in achieving the project objectives and to bring the intended outcomes. But in some kebeles they are not actively functioning as we demand*" [SN-G-KII-SCT].

The CCC in Girme kebele was established in October 2015 and meets once or twice per month to discuss "*issues related to PSNP. Meeting agendas include: issues of persons who don't properly engaging on PW, achievement of PW, and issues on moving PLW and caregiver of malnourished*

children to TDS" [SN-G-KII-CCC]. The frequency of meetings depends on the season; meetings take place more frequently at times of limited agricultural activity. This flexibility ensures that work on the CCC is feasible for its members. It also coincides with the schedule of PW: *"Yes, we have enough time and we scheduled our work in manner not to compete our agricultural activity. […] we have more meeting in sluggish agricultural times when most of PW are performed"* [SN-G-FGD-CCC].

Programme staff – including CCC members – indicated that long-term sustainability of the CCCs can be ensured through commitment of the kebele chairman and SWs as well as continued training and capacity building: *"I think its sustainability is depending on the commitment of the kebele chairmen and the social workers. May need refreshment training to the committee members and some sort of support to have proper documentations about the activities they are doing and the decisions made by the committee"* [SN-G-KII-SCT] and *"As long as additional training and capacity building continue the work will commence at same velocity"* [SN-G-FGD-CCC].

The regional SCT coordinator indicated that he considers the CCCs as a vital mechanism for ensuring that child protection and social protection issues remain on the agenda after the IN-SCT pilot has come to an end: *"CCCs at kebele level are found to be highly invaluable and are the basis for the IN-SCT programme and for incorporation of child/social protection issues as an agenda […] post [IN-SCT] activities at kebele […]"* [SN-KII-SCT].

9.2. Client perspectives

There is a stark contrast between perspectives of CCCs by clients compared to programme staff. The large majority of clients were unaware of the CCC's existence or its functioning. No one reported to have received any support from them.

Even after strong probing by the fieldworkers, the large majority of clients are not aware of the existence of the CCC in their kebele: *"We don't know about this committee. We only know the kebele administration"* [SN-G-FGD-PDS-F] and *"We don't know anything about CCC"* [SN-G-FGD-TDS-PLW]. Other respondents referred to having heard about a committee being in place but knowing about its remit: *"We heard that there is a committee organised from different government personnel in our kebele but we don't know what and to whom services and support they give"* [SN-G-FGD-PW-F].

Only the male PW clients were able to articulate the existence of the CCC and its functioning: *"The committee members are Kebele chairman and spokesman, DA, HEW, school director, elderly man, religious leader. The committee mobilise the people for PW, monitor on early marriage and girls abduction, advise us to practice what learnt from DAs and HEW and send school aged children to school"* [SN-G-FGD-PW-M].

As a result no clients apart from male PW client were able to reflect on any support received by the CCC. Fieldworkers probed any support that may have been received from members of the CCC individually, but did this not result in clear answers. The confusion is reflected in a quote by a female TDS client (caregiver of a malnourished child): *"SW, DA and Chairman gave me 200 Birr to support me when my kid was critical sick and couldn't recover as expected. I think that is personal support from those individuals and not a committee"* [SN-G-CS-TDS-F].

10.Management Information System (MIS)

A MIS was developed especially for IN-SCT pilot to support programme implementation, facilitate access to social services and undertake monitoring (Schubert, 2015). The Manual of Operations provides a clear overview of roles and responsibilities with respect to the use of the MIS (ibid). A MIS expert is to provide technical assistance at regional and woreda levels while SWs hold day-to-day responsibility for entering data into the system and keeping information on PDS and TDS clients updated.

10.1. Implementation of MIS

The implementation of the electronic version of the MIS has suffered severe delays. At the time of data collection in March 2017, the SWs and other key staff (from both Halaba and Shashego woredas) had just received an updated version of the software and training on how to use the software. The delay was a result of issues with the software that needed to be fixed. The SCT coordinator indicated: "[The MIS is] *not yet well functioning, Because of issues related to the software, its processes have lagged for a long time"* [SN-G-KII-SCT]. The newly hired WoLSA core process owner also mentioned issues with the software: *"I have heard that there is a software related problem to fully start with the data base"* [SN-G-KII-WoLSA]. The SW indicated that training had just been received and that entry of paper forms was to start soon: *"We received training last week and will start entering the forms"* [SN-G-KII-SW].

Data entry is supported and monitored by a woreda-level MIS focal person. In Halaba, this person had been recently recruited and started his job in January 2017 (less than 4 months before the interview for this survey). His tasks include quality control of all data that is entered by SWs and to provide support as appropriate. During the interview with the MIS focal person it became apparent that his knowledge of the MIS and its functionings was fairly limited. He refers quite strictly to the MIS Manual by Development Pathways (July 2016) to provide answers about the functionalities of the MIS rather than his own experience. This can be explained by having only recently started his position and also not having been able to work with a fully functioning MIS yet. Having technical capacity in-house was mentioned by the SCT coordinator as a key recommendation for improving the MIS: *"Capacitate the MIS officer to have skills to fix commonly observed errors by providing troubleshooting training* [to the officer]" [SN-G-KII-SCT].

Despite these challenges, the MIS was generally considered to be a positive component in facilitating day-to-day implementation. The WoLSA SP core process owner indicating that ICT is an important factor in any type of service provision. The Regional SCT coordinator said: *"I believe the MIS helps a lot because it helps to* [provide] *easy access of client data at any times, and reduces the work load of social workers by avoiding manual filling each information on all forms"* [SN-RSCT]. He also flagged the importance of the MIS in regional and national-level monitoring of the IN-SCT:

> *"As to moving the data to region and national level, the MIS has an exporting and importing options. First the data will be exported from the woreda server to the regional server, then it will be imported by the MIS officer to the server at the region. Moving the data to the national MIS follows the same process where it will be exported from regional server and then imported to the server at federal MoLSA"* [SN-RSCT].

Next steps in the implementation of MIS revolve around the entry of the backlog of data on PDS and TDS clients. This is to be done by each SW individually: "*Back log data should be entered quickly by campaign with full involvement of the SWs; at least every SW should enter his own data"* [SN-G-KII-SCT]. The MIS focal person indicated that some SWs have already started this process but that a

technical error remains, limiting the extent to which the process can be completed: *"form 4c is receiving data but the software is not saving it – it is still not functioning"* [SN-G-KII-MIS]. The SCT coordinator flagged the lack of capacity on behalf of the MIS focal person to fix technical problems and staff turnover as main challenges to successful implementation and long-term use: *"I am highly reserved on its sustainability, because it is more depending of the skill and commitment of the MIS person. Staff attrition will seriously affect its sustainability"* [SN-G-KII-SCT].

10.2. Use of forms

The MIS is set up around a set of standardised forms for data entry and monitoring purposes along different stages of programme implementation. There are six sets of forms, each set being tailored for PDS clients ('A' forms), PLW who are TDS clients ('B' forms) and caregivers of malnourished children who are TDS clients ('C' forms).

Forms 1A, B and C are used for collecting basic information from all clients and their fellow household members, including sex, age and nutritional status. These forms are to be completed by SWs with support from HEWs or DAs if necessary.

Forms 2A, B and C list all PDS and TDS clients' household members and the social services to be used by them (i.e. co-responsibilities) by kebele. These forms are generated by the MIS and are based on the information on individual household member in combination with information on available services within the respective kebele. These forms provide an overview of the services to be provided and co-responsibilities to be adhered to at kebele level and serve programme monitoring purposes.

Forms 3A, B and C list the co-responsibilities for each individual household member. These forms are generated by the MIS and provide an overview of co-responsibilities by individual. These forms are to be handed over to PDS and TDS clients so that they hold a record of which services they are to use.

Forms 4A, B and C list the names of clients and their household members needing to use a particular service in a given kebele and asks to check whether individuals have used that particular service. These forms are generated by the MIS and are to be used by the relevant service providers for monitoring adherence to co-responsibilities. For example, form 4A lists is to be used by the school director and teachers to check whether children of PDS and TDS clients of school-going age are attending school.

Forms 5A, B and C represent case management forms for each member in PDS and TDS client households. These forms are generated by the MIS in case a member has not complied with a co-responsibility as listed in Forms 3A, B and C respectively. The SW will use this form register reasons for non-compliance and suggested actions for improvement. This information is to be entered into the MIS by the SW.

Forms 6A, B and C represent monthly reports on the performance of co-responsibilities and services used by kebele. The forms are generated by the MIS and list the sets of co-responsibilities that are relevant for the respective client group (PDS, TDS-PLW or TDS-caregivers) and provides and overview of the number of clients having to comply with the co-responsibilities, the number having failed to comply, number of household visits in response to non-compliance and reasons for non-compliance for each of these co-responsibilities.

Although the electronic processing of these forms using the MIS has suffered delays to technical issues, SWs have used paper versions in support of a paper-based monitoring system. The MIS focal person explained and showed that SWs have collected information of all PDS and TDS households using Forms 1A, B and C and that they have used this information in combination with information on available services in the respective kebeles to fill Forms 2A, B and C as well as forms 3A, B and C and

4A, B and C (see Picture 1 for examples of Forms 1A, 2A, 3A and 4A that were completed for PDS clients). All forms were organised by kebele in large folders by the SW responsible for the respective kebele. According to the MIS focal person, Forms 5A, B and C and Forms 6A, B and C had not yet been created as the process of case management has not yet started.

Picture 1. Examples of Forms 1A, 2A, 3A and 4A for PDS clients
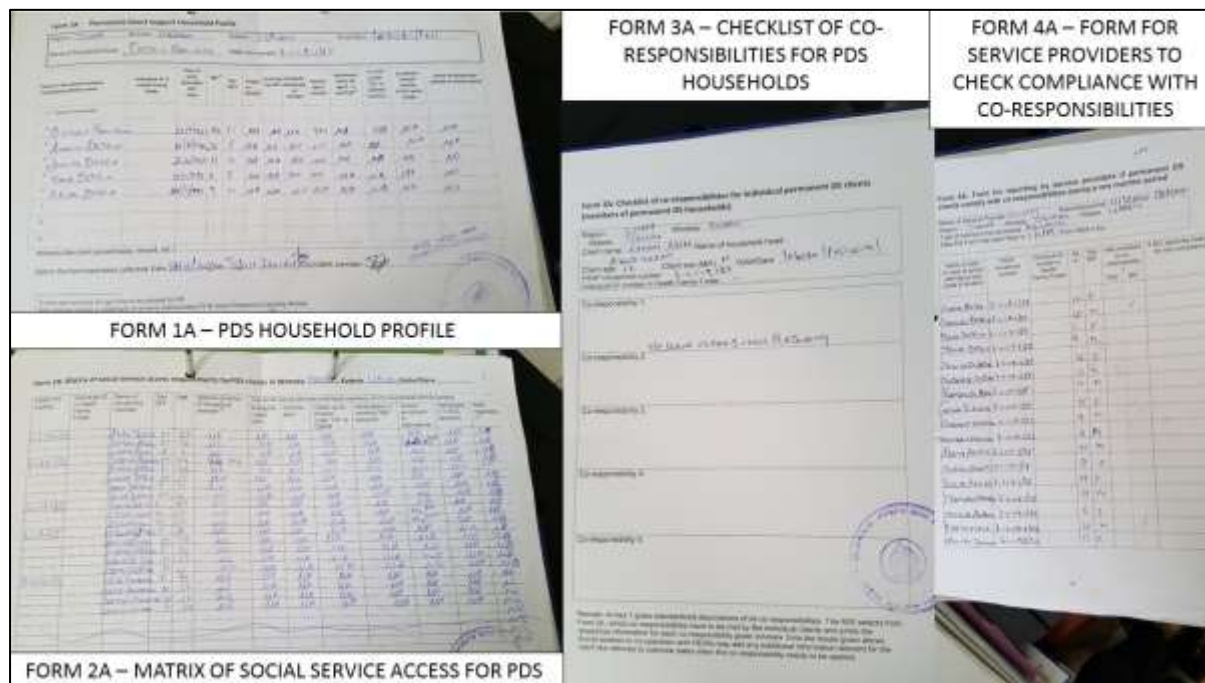
The observation of the folders and forms confirm findings from discussions with clients regarding the provision of information about co-responsibilities. As indicated in the IN-SCT Manual of Operations, clients should have received Forms 3A, B or C respectively for each member needing to comply with soft conditionalities. However, during the discussions, clients indicated that they had not received any form listing their co-responsibilities. The fact that Forms 3A, B and C are present in the folders in the woreda office confirms that they have indeed not been handed over to the clients. This is confirmed by the SCT coordinator, who indicates that the use of English limits the usefulness of these forms as a means of communicating co-responsibilities to clients: *"We are using […] forms; but we don't give to the clients as these forms are written in English and thus we are using for internal communication for the SW, HEWs and DAs"* [SN-G-KII-SCT].

11. Challenges and lessons learned

In this final section we provide an overview of findings structured along three OECD-DAC evaluation criteria, namely efficiency, effectiveness and sustainability. For each programme component as analysed in this report, we present positive experiences and bottlenecks in relation to the evaluation criteria. As the parameters of these criteria overlap, some findings are relevant for more than one criteria. Findings are primarily based on direct responses as provided by service providers and clients but also include the authors' interpretations of findings in reference to the wider context.

We also discuss operational challenges to be addressed in implementation of the remaining period of IN-SCT.

11.1. *Efficiency*

Based on the discussion above, this section considers to what extent programme components are implemented according to programme guidelines, identifying positive experiences and bottlenecks or improvements to implementation as suggested by respondents.

	Positive experiences	Bottlenecks
Transfer to TDS of PLW and caregivers of malnourished children	- Strong awareness of process and criteria among service providers and clients regarding transfer of PLW and caregivers of malnourished children to TDS - Good implementation of transfer of PLW to TDS - Fair implementation of transfer of caregivers of malnourished children to TDS	- Women have to travel far and pay for their pregnancy tests to prove pregnancy - Women with babies returning to PW after one year have problems finding care for their babies
Co-responsibilities	- Improved and high awareness of co-responsibilities among service providers and clients - Strong monitoring by SWs and HEWs - Good collaboration between service providers for monitoring and follow-up including SWs, HEWs, DAs and school teachers/ directors	- Only oral information provided; no official form has been distributed - Delay in cash transfer payments make it difficult to adhere to co-responsibilities - Small amount of cash transfer make it difficult to adhere to co-responsibilities - Limited awareness of importance of education, health and sanitation practice prevent clients from adhering to co-responsibilities - High caseloads limit SWs' capacity to monitor and provide follow-up
Case management (beyond IN-SCT)	- Strong collaboration between service providers, including police and justice system	- Identification and management of cases happens on ad hoc basis
Grievance mechanisms	- Well-established grievance mechanism is in place - Strong awareness of the existence of a grievance mechanism on behalf of service providers	- Limited to no link to IN-SCT case management - SWs play limited to no role in mechanism

		- Very limited awareness of the existence of a grievance mechanism on behalf of clients
Social services *Social Workers*	- Clients have positive experiences with SWs and find the support helpful - Non-clients experience the support SWs as being positive for the community	- Community and home visits by SWs are not as frequent as desirable - Lack of adequate transportation to reach all kebeles
Health Extension Workers	- Community-wide exposure to support by HEWs on health and sanitation issues	- Home visits of HEWs too infrequent - Lack of medical supplies to provide treatment - Lack of capacity and knowledge to provide treatment - Inability for clients and non-clients to act on advice due to financial constraints
Development Agents	- Community-wide exposure to support by DAs on agriculture	- Unequal frequency of visits to areas that are nearer or further away - Tensions regarding adequacy and fairness of distribution of inputs, with some community members claiming PSNP clients to be favoured
Overall collaboration	- Woreda Steering Committee supports greater levels of collaboration - Training has improved awareness and collaboration of HEWs - Good collaboration at kebele level	- High staff turnover - Lack of clear TOR for Woreda Steering Committee - Lack of regular meetings between service providers at implementation (kebele level)
Collaboration between MoLSA and MoARD	- Shift of responsibilities has helped to spread workload	- Resistance on behalf of MoARD to shift Direct Support to MoLSA - Delay in payments for DS clients due to ineffective handover of client lists
Collaboration with Concern	- Implementation of wide range of interventions making IN-SCT more nutrition-sensitive - Working in close collaboration with service providers at woreda and kebele level being embedded in implementation structures - Helpful support to service providers at kebele level, notably to HEWs	- Flooding and security situation undermining ability to carry out activities in appropriate and timely manner - Logistical challenges due to lack of appropriate transportation - Delays in implementation due to delayed provision of (training) materials - Constrained collaboration with local government and other service providers due to competing pressured.

Community Care Coalitions (CCCs)	- Positive input into programme implementation, including targeting and monitoring of co-responsibilities, as experienced by service providers	- Large differences between CCCs and their functioning across kebeles - Very limited awareness of existence of CCC on behalf of clients - No support received from CCC as reported by clients
Management Information System (MIS)	- MIS facilitates monitoring of co-responsibilities - All staff have recently received training on how to use MIS - Strong paper-based record has been held in absence of electronic MIS	- Severely delayed roll-out of MIS with backlog of data to be entered - Forms produced by MIS are in English rather than local language

11.2. Effectiveness

This section summarises the perceived effectiveness of the programme as based on respondents' answers regarding impact or change as a result of IN-SCT.

We consider the effectiveness of all programme elements as relevant, and add additional observations. For example, data did not provide clear findings with respect to effectiveness of the overall collaboration between service providers or between MoLSA and MoARD. Conflicting findings with respect to the role of CCCs in programme implementation based on service providers versus clients and the delayed roll-out of the MIS prevent insight into the potential effectiveness of CCCs and MIS. Yet the issue of drought and lack of access to potable water emerges as a key constraint for the programme to be effective (see also section 11.4.4).

	Positive experiences	**Bottlenecks**
Transfer to TDS of PLW and caregiver of malnourished children	- Transfer to TDS reduces burden on women	- Limit of transfer to TDS for PLW until the child is one year old may undermine outcomes after child turns one year old
Co-responsibilities	- Improved awareness and understanding of need for education and hygienic practice on behalf of clients	- Advice following non-compliance with co-responsibilities not always provided in positive manner leading to shame - Delay in cash transfers and small amounts prevents clients from adhering to co-responsibilities and achieving positive change
Case management (beyond IN-SCT)	- Children are returned to their families in cases of abduction	- No psychosocial support is provided - Case management only covers a few cases
Grievance mechanisms	N/A	N/A
Social services *Social Workers*	- Improved awareness of rights and responsibilities within PSNP, including transfer to TDS	- Lower frequency of (home) visits to clients and limited presence in communities undermines potential effectiveness

	- Positive encouragement to improve children's outcomes as perceived by clients - Positive impacts on school enrolment and hygiene, feeding and health practices as reported by service providers - Positive impacts on school enrolment and hygiene, feeding and health clients	
Health Extension Workers	- Improved awareness of hygienic practice, including hand washing and building latrines - Improved health-seeking behaviour, including vaccination and antenatal and postnatal care	- Delay in cash transfers and small amounts prevents clients from adhering to co-responsibilities and achieving positive change - Advice – such as on building of latrines - is not always provided in positive manner leading to shame - Lack of medical supplies and limited capacity to diagnose health issues or knowledge about how to respond to them can undermine impact
Development Agents	- Improved knowledge and awareness of agriculture practices	- Lower frequency of visits to remote areas undermines impact - Advice may be too theoretical or technical and not address practical problems in agriculture (such as floods)
Overall collaboration	N/A	N/A
Collaboration between MoLSA and MoARD	N/A	N/A
Collaboration with Concern	- Support to cooking demonstrations have increased awareness of feeding practices	- Delays in implementation undermine effectiveness
Community Care Coalitions (CCCs)	N/A	N/A
Management Information System (MIS)	N/A	N/A
Other		- Drought and lack of access to potable water undermines programme impact in all outcome areas

11.3. Sustainability

This section considers the future of the programme and its changes, providing insight into respondents' opinions about the long-term sustainability of the programme and its impacts. Questions about sustainability were primarily administered to service providers; the findings below reflect their views as well as our own interpretation of findings.

	Positive experiences	Bottlenecks
Transfer to TDS of PLW and caregivers of malnourished children	- Improved awareness among all service providers (and HEWs in particular) contributes to sustained efficient implementation of co-responsibilities after IN-SCT	
Co-responsibilities	- Improved awareness among all service providers (and HEWs in particular) contributes to sustained efficient implementation of co-responsibilities after IN-SCT	- Majority of SWs are not government-staff and may no longer be in place after IN-SCT ends to follow up on implementation of and adherence to co-responsibilities
Case management (beyond IN-SCT)	- Experience with cases and improved awareness of how to respond to cases may encourage case management after IN-SCT	- SWs already have limited capacity to undertake case management beyond IN-SCT; capacity constraints may grow after end of IN-SCT
Grievance mechanisms	- Mechanism is well-established under PSNP and will be in place in the long term	- Limited awareness on behalf of clients limits its practical use
Social services *Social Workers*	- Positive experiences with social workers on behalf of clients and service providers may convince government to take on SWs after IN-SCT ends	- Majority of SWs are not government-staff and may no longer be in place after IN-SCT ends
Health Extension Workers	- Improved awareness and experience with IN-SCT may contribute to sustained efficient implementation of co-responsibilities and transfer to TDS after IN-SCT	- Without follow-up by SWs and in light of high workload, support to PSNP clients may be undermined after IN-SCT ends
Development Agents	- DAs are already integrated part of PSNP	
Overall collaboration	- Experiences obtained through IN-SCT in terms of monitoring, follow-up and case management may institutionalise collaboration	- Weak commitment of service providers may waiver further without strong impetus from IN-SCT and SCT coordinator - High staff turnover undermines consistency of implementation and sustainability
Collaboration between MoLSA and MoARD	- Experience with change in roles and responsibilities may institutionalise collaboration	- Reluctance on behalf of MoARD to shift Direct Support to MoLSA may undermine future collaboration
Collaboration with Concern	N/A	N/A
Community Care Coalitions (CCCs)	- Can be supported through commit-ment of kebele chairman and SWs - Can be supported through ongoing provision of training and capacity building	

Management Information System (MIS)	- Positive experiences with MIS may help for it to be integrated within PSNP at large	- Lack of in-house expertise on software may undermine sustainability

11.4. Operational challenges

Reflecting on the overall analysis and the assessment of positive experiences and bottlenecks in reference to efficiency, effectiveness and sustainability, we reflect on operational challenges that require consideration to improve programme implementation and its impacts. These challenges primarily pertain to issues that compromise the performance of service providers' roles in the IN-SCT. They can be categorised as relating to staffing issues (attrition, recruitment delays, work overload, language barriers), technical problems (delayed MIS software development, late payment of PSNP clients), logistical constraints (lack of transport, remote communities), and practical issues that affected clients' participation (poor attendance at meetings, water shortage, infirmity).

11.4.1. Staffing challenges

Respondents reported worryingly high levels of **staff turnover**. In Halaba Special woreda, 5 out of 10 staff who were hired for the project resigned – 4 Social Workers and 1 MIS officer – three within three months and two within one year. The reasons why the Social Workers resigned were related to **work overload** and **low pay**. *"The work volume and the stress they usually faced, and the monthly salary payment is not compatible – the salary is very low compared to the workload"* [SN-G-KII-SCT]. *"The social workers are tight with work overload"* [SN-G-KII-WoLSA].

Another factor is **appropriate capacity and local knowledge** of service providers. Respondents pointed at the social distance between social workers, most of whom come from elsewhere in Ethiopia, and clients. *"Shortage of educated or trained staff who can understand the local context, including language, is creating barriers in communication between social workers and communities"* [SN-G-FGD-SCT]. Clients indicated that the HEWs lacked the knowledge to diagnose and respond to medical issues and that the DAs offered strong theoretical knowledge but was not always able to provide practical solutions.

Recruitment processes are complicated and slow, which makes hiring and replacing staff challenging. *"There is a great challenge to substitute other staff in place of those who left, due to hectic procedures and bureaucracy. It takes up to 6 months to hire one staff. For instance; the hiring process of the MIS officer has taken exactly 6 months"* [SN-G-KII-WSCT].

Apart from staff attrition, key staff – especially HEWs and DAs – sometimes take extended **leaves of absence** for education or training, which leaves critical gaps in service delivery. *"They are not simply leaving their jobs but sometimes they are called for education and then they are absent from their jobs for months. There is no replacement"* [SN-G-KII-SW].

11.4.2. Technical challenges

Technical glitches in developing the **MIS software** have delayed the computerisation of client data leading to a backlog of data: *"The MIS software development was so lagged and not yet fully started till today. Due to this we have a huge backlog of data; it will be a headache to enter"* [SN-G-KII-WSCT].

Late payment of clients was identified as another technical challenge, undermining expectations of the programme as well as its potential to achieve positive impacts and clients' abilities to adhere to

co-responsibilities. Several factors contributed to this, including bureaucratic procedures, disrupted internet access, and problems with agents.

> *"The main challenge is delay of transfers due to fund transfer delay from the region. There was also a problem of internet connectivity, this also contributed to delay of the transfer. The transfer have been handled by an OMO agent. Some agents lost their pin, in such cases delays happened until a new pin was given to the agent from the region"* [SN-G-KII-PSNP].

11.4.3. Logistical challenges

Each social worker has responsibility for several kebeles, which requires them to **travel** to different communities to do their day-to-day work. Staff have been allocated motorcycles but some communities are remote and difficult to get to, even by motorcycle. *"There are some hard to reach areas by motorcycle, due to poor road infrastructure"* [SN-G-KII-WoLSA]. One SCT Steering Committee member highlighted mobility as *"the biggest challenge"*:

> *"The large number of kebeles and distance between kebeles is the biggest challenge. The ratio of kebeles to social workers is very high – five to seven kebeles per social worker. This coupled with shortage of transport cripples supervision of activities – they share few motorbikes with little budget. It is very difficult to coordinate activities as social workers and supervisors cannot reach all their kebeles in a month. Due to this he or she may lack important details of the project situation in the kebeles, and cannot provide technical support as required"* [SN-G-FGD-SCT].

Even within some kebeles, **distances** to the furthest villages are challenging, even for health extension workers who are based in the kebele. *"I couldn't reach the entire villages in the kebele as some are too far from the kebele centre"* [SN-G-KII-HEW].

Similar logistical constraints were reported for DAs and HEWs. This raises concerns that some communities might be under-served by IN-SCT/PSNP service providers, especially those based at woreda level. Even more worrying, those communities that are neglected are likely to be the most remote and most deprived of services for which they have the greatest needs.

11.4.4. Practical challenges

Non-attendance of PSNP clients at project meetings and BCC sessions was mentioned by several social workers and health workers. A social worker explained that this was a particular challenge with PDS clients, because PW and TDS clients can be located, but PDS clients are not so easy to find.

> *"At community level the people are not coming to meetings satisfactorily – some come and other don't come. This refers mostly to PDS. Public Works clients can be met at the worksite but when it comes to PDS, we call them and they may not come. Because the population is dispersed, it becomes difficult to meet all the households. In terms of TDS there are different ways to get information. One is through the service providers and another is through the husband at the public works site. There are not so many of them and we might also reach them in their home"* [SN-G-KII-SW].

Health extension workers also reported non-attendance by clients at health posts. *"They also don't come to the health post for community meeting. As a result, some households have lack of awareness about all health related issues"* [SN-G-KII-HEW].

Some PDS clients physically cannot come to the health post because they are chronically ill, or elderly and infirm. Moreover, their **physical incapacity** prevents them from following the advice they receive – about constructing safe sanitary facilities, for instance. *"Some of the PDS are also unable to construct*

latrine and even can't have good hygiene and sanitation because they are very old and can't even stand up from their bed" [SN-G-KII-HEW].

A final practical challenge mentioned was related to the **ongoing drought** in southern Ethiopia, which reduced household access to water and make it impossible for PSNP clients to follow good hygiene and sanitation practices, such as hand-washing. One response to the drought was to install additional water-points, which alleviated the water crisis, at least for households in the vicinity.

"Previously there was a water problem. Families were sending children to fetch water instead of going to school. Because of the shortage of water, people were not practicing what they learned about hygiene and sanitation. But now a public water point is constructed at the centre of the kebele and the problem has been solved to a large extent. However, the problem is still there for people living in villages very far from the water-point" [SN-G-KII-HEW].

12.Conclusion and recommendations

This midline study aimed to provide insights into the efficiency, effectiveness and sustainability of the IN-SCT pilot project as part of the wider implementation of PSNP4. It provided findings from a selected kebele in Halaba Special woreda in SNNPR based service providers, PSNP clients and non-clients' perspectives. In this section we provide an overview of findings – also drawing comparisons to baseline findings – and suggest various recommendations for addressing bottlenecks and challenges as presented above.

12.1. Overall findings

The implementation of the pilot can largely be considered to be **efficient**. Awareness of co-responsibilities and transfer of PLW from into TDS is high among both service providers and clients and well implemented. Awareness and practice has improved in comparison to the baseline, at which time awareness and implementation of responsibilities on behalf of HEWs was particularly weak. Service providers, including SWs, DAs, HEWs in particular, are now very aware of their respective roles and responsibilities and operate in a collaborative manner towards monitoring and follow-up of co-responsibilities of PDS and TDS clients. Across all project components, the transfer of caregivers of malnourished children from PW into TDS remains relatively less well understood, although knowledge and practice appears to have improved in comparison to baseline.

Strong collaboration across sectors and services, including those that do not have a direct role within the PSNP and IN-SCT such as the police, was also evidence from the examples of child protection case management and can at least in part be attributed to the IN-SCT pilot and the ways in which it promotes and supports cross-sectoral collaboration. The woreda-level steering committee and committee meetings were considered as vital for supporting collaboration and to have contributed to an improvement in awareness of roles and responsibilities since baseline. Service providers also considered the role of CCCs to be positive and important, particularly in relation to targeting and monitoring and follow-up on co-responsibilities but strikingly only a minority of clients knew of the existence of the CCC. Although experiences vary across kebeles, their role and contribution to IN-SCT may have diminished after baseline with CCCs grappling to hold on to their momentum after establishment in early 2016 due to many other pressures on members' time and resources.

Implementation of nutrition-sensitive components by Concern was largely assessed as progressing well by Concern coordinating staff but also suffered from delays and implementation problems. The NGO plays a crucial role in reinforcing the nutrition-sensitive nature of the pilot project with activities ranging from setting up Farmer Training Centres (FTCs), providing cooking demonstrations to setting up school gardens. Their emphasis on playing a catalytic role rather than being a key implementer means that their support is less visible to clients as being distinct from government services, making it harder to assess the extent of Concern's work.

The IN-SCT pilot project can also be considered to be **effective**. Most programme components appear to significantly contribute to reaching programme objectives, as based on service providers' and clients' perspectives. The monitoring and follow-up of co-responsibilities contributes towards better knowledge and awareness on the importance of education and hygiene practices while the awareness creation and referral mechanisms supporting the transition from PW into TDS has been effective to lessen the burden on PLW in particular.

Services provided by SWs, HEWs and DAs appear largely effective, both in their own right and in collaboration. Clients appreciated the advice and support received by all and reported greater knowledge of the PSNP itself and awareness of practices to improve children's outcomes, including

feeding and handwashing practices, the need for building latrines, getting children immunised and seeking antenatal and postnatal care as well as agricultural practices. It should be noted that knowledge on exclusive breastfeeding, handwashing practices and health-seeking behaviour was already high for most clients at baseline. Effectiveness of services – and the extent to which advice and awareness is translated into practice – is constrained by delays and small amounts of cash transfer payments, the relatively low frequency of home visits particularly in remote areas and advice not always being provided in a supportive manner. Lack of (easy) access to potable drinking water remains a serious barrier to effectiveness, as was identified in the baseline survey.

Finally, opinions regarding **sustainability** of mechanisms put in place by the pilot – such as the monitoring and follow-up by SWs and the MIS – are mixed. Those holding positive views emphasise that cross-sectoral collaboration has always existed and that the levels of integration and awareness as promoted by the pilot serve as a strong foundation for sustaining future collaboration. Positive experiences regarding collaboration at the community, kebele and woreda level can help to harness collaborative implementation of services in the future.

At the same time, high staff turnover, strong pressures on staff time and varying levels of commitment may undermine the potential for long-term success. The fact that SWs – key actors in this pilot – are not government staff and may not be taken on as government employees after the end of the project is a real concern. Not only would this undermine the support to PDS and TDS clients but it may also have knock-on effects for the support provided by DAs and HEWs as they are no longer able to spread the workload with SWs.

12.2. Recommendations

We present various recommendations to be taken into account into further implementation of the IN-SCT pilot and future phases of PSNP. These are based on respondents' suggestions as provided in the research and suggestions following the analysis in this report.

Coordination

- Provide a clearer Terms of Reference (TOR) or protocol for the woreda-level IN-SCT Steering Committee, ensuring clarity of roles and responsibilities and offering an accountability framework for its individual members;

- Introduce regular coordination meetings for service providers at community-level, allowing for greater sharing of knowledge and a more coordinated response between SWs, DAs, HEWs, school directors and CCCs working in a given kebele or community. This could also include police and judicial services in order to better coordinate response to child protection cases;

- Strengthen linkages between the IN-SCT case management system and PSNP grievance mechanism in order to improve and streamline the response to any complaints by PSNP clients.

Staffing and staff capacity

- Provide ongoing training on PSNP and IN-SCT in support of new staff following high staff turnover, particularly in WoLSA but also among DAs and HEWs. This can avoid implementation gaps and undue pressure on existing staff to fill such gaps and can ensure a continued quality of implementation;

- Improve awareness on child protection issues among all service providers to strengthen identification of cases and support a coordinated response of such cases. This would also involve stakeholders beyond PSNP and IN-SCT such as the police and judicial services;

- Improve awareness on child protection issues among community members to ensure a better understanding of what constitutes child protection and violations thereof and – crucially – service providers' roles in preventing and responding to violations. This will improve the identification of cases and formulation of adequate responses by service providers;

- Provide training for service providers regarding the newly established procedures for vital registration and their role in facilitating birth registration, among others. This is to be coupled with awareness raising among community members, ensuring that all are aware that birth registration is a separate process from having a birth recorded at the health facilities only;

- Develop a clearer mandate for CCCs, accompanied with ongoing capacity building of its members (with respect to PSNP, child protection and more broadly) and awareness raising of PSNP clients and community members, thereby picking up on momentum created at time of establishment of CCCs and more firmly institutionalising CCCs at community-level;

- Find ways to lessen the workload of SWs, such as decreasing the caseload by increasing the number of SWs, improving mobility by providing more appropriate means of transport or closing the distance between SWs and their clients by basing them in the kebele rather than woreda;

- Strengthen in-house technical capacity regarding MIS and its software so as to improve the ability to respond to any technical issues and reduce dependency on outside partners.

Implementation

- Provide more standardised messaging and visual information in order to strengthen general awareness about co-responsibilities among PSNP clients but also offer clarification to service providers.

- Create co-responsibility forms (forms 3) for PDS and TDS clients with primarily visual information in order to make the form useful for clients.

- Increase cash transfer amounts (at very least) in line with inflation and ensure on-time payment in a bid to make the programme more effective.

- Integrate construction of child care centres into PW activities, ensuring that care facilities are available within the community or at the work site when women resume work after their child is one year old.

- Create awareness among community members that HEWs' mandate is to provide preventive care rather than treatment. This will help to create understanding among community members and thereby reduce frustration on behalf of both community members and HEWs over unmet expectations.

- Allow for and support HEWs to undertake pregnancy tests within the community or at the kebele health post, preventing women having to travel far and incurring expenses.

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